Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2004

Summary of Auditor's Results

FINANCIAL STATEMENTS

- We issued an unqualified opinion on the state's financial statements.
- We found no significant deficiencies in the design or operation of internal control over financial reporting that we consider a reportable condition.
- We noted no instances of noncompliance that were material to the financial statements of the state.

FEDERAL AWARDS

- Except for the Medicaid program, we issued an unqualified opinion on the state's compliance with requirements applicable to each of its major federal programs.
- We noted deficiencies in the design or operation of internal control over major federal programs that we consider to be reportable conditions. The following reportable conditions noted in this schedule are considered material weaknesses: 04-10, 04-15, 04-19, 04-20, 04-22, 04-25, 04-33, 04-34, 04-45 and 04-47.
- We reported findings that are required to be disclosed under OMB Circular A-133, Section 510(a).
- The dollar threshold used to distinguish between Type A and Type B programs, as prescribed by OMB Circular A-133, Section 520(b), was $30,000,000.
- The state did not qualify as a low risk auditee under OMB Circular A-133, Section 530.
- The following were major programs, determined in accordance with OMB Circular A-133, Section 520:

CFDA	PROGRAM
10.550	Food Donation
<u>Child Nutrition Cluster</u> 10.553 10.555 10.556 10.559	 School Breakfast Program (SBP) National School Lunch Program (NSLP) Special Milk Program for Children (SMP) Summer Food Service Program for Children (SFSPC)
16.523	Juvenile Accountability Incentive Block Grant
16.579	Byrne Formula Grant

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2004

Summary of Auditor's Results- continued

CFDA	PROGRAM
17.225	Unemployment Insurance
17.245	Trade Adjustment Assistance Workers
21.999	Jobs and Growth Tax Relief Reconciliation Act of 2003 Public Law 108-27
 84.027 84.173	Special Education Cluster Grants to States (IDEA Part B) Preschool Grants (IDEA Preschool)
 84.042 84.044 84.047	TRIO Cluster TRIO Student Support Services TRIO Talent Search TRIO Upward Bound
84.126	Rehabilitation Services-Vocational Rehabilitation Grants to States
84.318	Education Technology State Grants
84.334	Gaining Early Awareness and Readiness for Undergraduate Programs
84.367	Improving Teacher Quality State Grants
 93.044 93.045 93.053	Aging Cluster Special Programs for the Aging-Title III, Part B-Grants for Supportive Services & Senior Centers Special Programs for the Aging-Title III, Part C-Nutrition Services Nutrition Services Incentive Program
93.217	Family Planning Services
93.283	Centers for Disease Control

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2004

Summary of Auditor's Results- continued

CFDA	PROGRAM
93.558	Temporary Assistance for Needy Families
93.568	Low-Income Home Energy Assistance
93.569	Community Service Block Grant
 93.575 93.596	Child Care Cluster Child Care and Development Block Grant Child Care Mandatory and Matching Funds of the Child Care and Development Fund
93.667	Social Services Block Grant
93.767	State Children's Health Insurance Program
 93.775 93.777 93.778	Medicaid Cluster State Medicaid Fraud Control Units State Survey and Certification of Health Care Providers and Suppliers Medical Assistance Program (Medicaid: Title XIX)
93.958	Block Grants for Community Mental Health Services
94.006	Americorps
97.004	State Domestic Preparedness Equipment Support Program
Various	Research and Development Cluster

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2004

Financial Statement Findings

None reported. However, we do report instances of noncompliance with state laws and regulations that are not material to the state's basic financial statements in a separate accountability report. This report is available on our internet site at www.sao.wa.gov.

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2004

Summary of Federal Findings

Finding Number	Finding
04-01	The Department of Social and Health Services and the Health Care Authority did not provide the State Auditor's Office with records and resources needed to audit the Medicaid Program in a timely manner as required by Governmental Auditing Standards and federal regulations.
04-02	The Department of Social and Health Services, Medical Assistance Administration, did not provide the State Auditor's Office sufficient, reliable and timely records for our audit to determine if payments through the *Medicaid Management Information System* are made only for services provided before a client's date of death.
04-03	The Department of Social and Health Services paid providers with Medicaid funds through the *Social Services Payment System* for services provided to clients using Social Security numbers belonging to deceased persons.
04-04	The Department of Social and Health Services paid providers with Medicaid funds through the *Social Services Payment System* for services performed after the date of death.
04-05	The Department of Social and Health Services, Medical Assistance Administration, did not provide the State Auditor's Office reliable, timely records for our audit of services provided to undocumented aliens.
04-06	The Department of Social and Health Services, Medical Assistance Administration did not provide the State Auditor's Office with timely records and access to other sources of information needed to audit payments for certain types of procedures.
04-07	The Health Care Authority and the Department of Social and Health Services, Medical Assistance Administration, did not provide the State Auditor's Office with the records needed to audit the Basic Health Plus Program as part of Medicaid.
04-08	The Department of Social and Health Services, Medical Assistance Administration did not provide the State Auditor's Office with reliable, timely records for our audit of Proshare services.
04-09	The Department of Social and Health Services, Aging and Disability Services Administration, did not provide the State Auditor's Office with timely records we needed to determine if Medicaid payments are made only to nursing homes meeting federal health and safety standards.
04-10	The Department of Social and Health Services, Division of Developmental Disabilities, does not have adequate internal controls over its pharmacy drug inventory purchased with Medicaid funds.

Finding Number	Finding
04-11	The Department of Social and Health Services, Medical Assistance Administration, is not complying with federal regulations that require people receiving Medicaid payments to have valid Social Security numbers.
04-12	The Department of Health and the Department of Social and Health Services, Medical Assistance Administration, are not complying with state law or the provisions of the Medicaid State Plan that help to ensure compliance with health and safety standards for hospitals.
04-13	The Department of Social and Health Services, Medical Assistance Administration does not ensure that providers of motorized wheelchairs have the documentation required to substantiate claims for payment.
04-14	The Department of Social and Health Services, Medical Assistance Administration does not perform adequate reviews of providers of durable medical equipment to ensure the providers exist, are properly licensed, and have submitted accurate information.
04-15	The Department of Social and Health Services, Medical Assistance Administration, does not have adequate internal controls in its Medicaid Management Information System to prevent payments to providers with expired licenses.
04-16	The Department of Social and Health Services' Medical Assistance Administration and the Office of Accounting Services have not complied with federal regulations requiring the federal portion of cancelled warrants to be refunded to the Medicaid Program.
04-17	The Department of Social and Health Services' Office of Accounting Services has not complied with federal regulations requiring the federal portion of uncashed warrants to be refunded to the Medicaid Program.
04-18	The Department of Social and Health Services, Health and Rehabilitative Services Administration is not in compliance with the federal Medicaid requirements for reporting on adult victims of residential abuse.
04-19	The Department of Social and Health Services' Medical Assistance Administration and Division of Child Support have inadequate internal controls to ensure compliance with Medicaid requirements to identify third parties, usually insurance companies, responsible for payments for medical services.
04-20	The Department of Social and Health Services, Medical Assistance Administration has not established sufficient internal controls to ensure that rates paid to its Healthy Options managed care providers are based on accurate data.
04-21	The Department of Social and Health Services, Medical Assistance Administration, is not complying with federal requirements to report Medicaid expenditures properly.

Finding Number	Finding
04-22	The Department of Social and Health Services, Aging and Disability Services Administration, does not have sufficient internal controls to ensure it is complying with both subrecipient monitoring and matching requirements for the Medicaid Program.
04-23	The Department of Social and Health Services, Economic Services Administration, should improve compliance with eligibility requirements for the Temporary Assistance for Needy Families Program.
04-24	The Department of Employment Security paid at least $142,847 in unemployment insurance benefits to claimants who were not eligible. The Department also overpaid and underpaid eligible claimants by $18,873 and $5,150, respectively. In addition, we estimated that payments totaling more than $185,000 were made to claimants during their first week of unemployment, which is prohibited by state law.
04-25	The Department of Social and Health Services, Division of Child Care and Early Learning does not have adequate internal controls over support for payments made to child care providers.
04-26	The Department of Social and Health Services, Economic Services Administration, wrote-off child care overpayments to providers without adequate support and inappropriately decreased amounts owed to the Department by child care providers.
04-27	The Department of Social and Health Services, Division of Child Care and Early Learning, does not ensure that all recovered overpayments are credited to the appropriate funding source.
04-28	The Department of Social and Health Services, Economic Services Administration, did not properly monitor its contract with a non-profit organization that billed for services it did not provide.
04-29	The Department of Social and Health Services, Children's Administration, paid through the Social Services Payment System for services performed after a client’s date of death.
04-30	The Department of Social and Health Services, Mental Health Division, did not comply with state and federal regulations when contracting for services paid with federal Community Mental Health Services Block Grant funds.
04-31	The Office of Superintendent of Public Instruction did not comply with state and federal requirements when contracting for services paid with federal Title I funds.
04-32	The Department of Social and Health Services, Mental Health Division, did not comply with state and federal regulations when it inappropriately paid fixed administrative expenditures in advance of services for the Community Mental Health Services Block Grant.

Finding Number	Finding
04-33	The Department of Social and Health Services does not have adequate internal controls over the processing of expenditures through the Agency Financial Reporting System.
04-34	The Department of Social and Health Services does not have adequate internal controls over the Social Service Payment System.
04-35	The Department of Social and Health Services, Economic Services Administration, does not enter accurate information in its Random Moment Time Sample to ensure administrative costs are properly charged to federal and state funds.
04-36	The Department of Social and Health Services did not comply with federal requirements for an independent peer review of the Community Mental Health Services Block Grant.
04-37	The Department of Community, Trade and Economic Development did not comply with federal requirements for suspension and debarment.
04-38	The Department of Community, Trade and Economic Development did not comply with federal requirements for time and effort reporting.
04-39	The Department of Social and Health Services, Division of Vocational Rehabilitation, did not comply with federal time and effort reporting requirements for its Rehabilitation Services grant.
04-40	The Department of Social and Health Services, Juvenile Rehabilitation Administration did not comply with federal requirements for time and effort reporting for the Juvenile Accountability Incentive Block Grant Program.
04-41	The Military Department did not comply with federal requirements for time and effort reporting in the State Domestic Preparedness Equipment Support Program.
04-42	The Department of Social and Health Services, Economic Services Administration, does not adequately monitor other state agencies to which it provides funds from the federal Temporary Assistance For Needy Families Program.
04-43	The Department of Social and Health Services, Juvenile Rehabilitation Administration is not complying with subrecipient monitoring requirements for the Juvenile Accountability Incentive Block Grant.
04-44	The Department of Social and Health Services, Health and Rehabilitative Services Administration, does not adequately monitor its subrecipients for the Community Mental Health Services Block Grant.

Finding Number	Finding
04-45	The Military Department does not have adequate internal controls to ensure compliance with regulations regarding purchases for, contracting with, and monitoring of its subrecipients in the State Domestic Preparedness Equipment Support Program.
04-46	The University of Washington did not comply with federal cost principles for its research and development programs.
04-47	The Employment Security Department does not have adequate internal controls over the reporting of grant expenditures on the Schedule of Expenditures of Federal Awards.
04-48	The Employment Security Department did not comply with federal requirements for time and effort rep
04-49	The Department of Social and Health Services' Medical Assistance Administration did not comply with allowability and reporting requirements for the State Children's Health Insurance Program.

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2004

Summary of Questioned Costs

Federal Grantor	State Agency	CFDA No.	Federal Program	Questioned Costs	Finding No.
U.S. Department of Health and Human Services	Department of Social and Health Services	93.778	Medicaid	**(Note 1)**	04-01 to 04-22
U.S. Department of Health and Human Services	Department of Social and Health Services	93.558	Temporary Assistance for Needy Families	$19,965	04-23
U.S. Department of Labor	Employment Security Department	17.225 **(Note 2)**	Unemployment Insurance	$351,870	04-24
U.S. Department of Health and Human Services	Department of Social and Health Services	93.575 93.596	Childcare Cluster	$1,100,000	04-25
U.S. Department of Agriculture	Department of Social and Health Services	10.561	State Administrative Matching Grants for the Food Stamp	$550,000	04-28
U.S. Department of Health and Human Services	Department of Social and Health Services	93.659	Adoption Assistance	$8,275	04-29
U.S. Department of Health and Human Services	Department of Social and Health Services	93.958	Mental Health Block Grant	$882,862	04-30 04-32
U.S. Department of Health and Human Services and the U.S. Department of Agriculture	Department of Social and Health Services	93.558 93.566 93.596 93.667 93.778 10.561	Temporary Assistance for Needy Families Refugee and Entrant Assistance Child Care Development Fund Social Service Block Grant Medicaid State Administrative Matching Grants for the Food Stamp Program	$101,316,240	04-35

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2004

Summary of Questioned Costs - continued

Federal Grantor	State Agency	CFDA No.	Federal Program	Questioned Costs	Finding No.
U.S. Department of Health and Human Services	Department of Community, Trade and Economic Development	93.568 93.569	Low-Income Home Energy Assistance Community Services Block Grant	$56,500	04-38
U.S. Department of Education	Department of Social and Health Services	84.126	Rehabilitation Services-Vocational Rehabilitation Grants	$89,750	04-39
U.S. Department of Justice	Department of Social and Health Services	16.523	Juvenile Accountability Incentive Block	$565,000	04-40
U.S. Department of Homeland Security	Military Department	16.007 97.004 **(Note 3)**	State Domestic Preparedness Equipment Support	$75,000	04-41
U.S. Department of Health and Human Services	University of Washington	93.846 93.856	Research and Development Cluster	$36,509	04-46
U.S. Department of Labor	Employment Security Department	17.245	Trade Adjustment Assistance - Workers	$130,515	04-48
U.S. Department of Health and Human Services	Department of Social and Health Services	93.767	State Children's Insurance Program	$26,300,000	04-49
			TOTAL	**$131,482,486**	

Note 1 – Evidence was insufficient to provide a basis for an opinion of reasonable assurance for the Medicaid program. Audit exceptions noted in the Medicaid findings result from the limited tests performed for that program. Because of the agency-imposed scope limitations and external impairments to the performance of the 2004 Medicaid audit, the State Auditor's Office has disclaimed on the opinion for this $6.1 billion program as outlined in finding 04-01.

Note 2 – The costs listed in finding 04-24 relate to unemployment benefits paid from state unemployment tax revenues that are deposited into Unemployment Trust Fund. Although these payments are not costs charged to a federal award, they are subject to audit under OMB Circular A-133 and reported in a manner similar to federal questioned costs.

Note 3 – This finding 04-41 relates to federal funding that was initially funded by the U.S. Department of Justice but the program was transferred to the U.S. Department of Homeland Security.

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2004

Federal Findings and Questioned Costs

04-01 The Department of Social and Health Services and the Health Care Authority did not provide the State Auditor's Office with records and resources needed to audit the Medicaid Program in a timely manner as required by Government Auditing Standards and federal regulations.

Background

The federal Office of Management and Budget's Circular A-133 Compliance Supplement for its *Audits of States, Local Governments, and Non-Profit Organizations*, stipulates which areas of a federal program must be considered during audit planning and procedures. Governmental Auditing Standards require the Auditor to examine both controls and compliance in each area, focusing on matters that appear to be high risk. The Standards also require that any issues from the previous year's audit be reviewed annually for at least three years, until the condition is either resolved or the federal government determines the matter is immaterial.

Auditors must be able to complete the audit procedures they feel are necessary to obtain reasonable assurance that the state is complying with federal regulations. At the end of the audit, the auditor is required to provide an opinion on compliance for each area reviewed.

For Medicaid, the auditor must review 16 compliance and special test areas, including the all-encompassing issues of allowability of payments and eligibility of clients and providers. Because of the size and complexity of the Medicaid program, it is not possible to include all types of Medicaid expenditures in any one year's review. Analysis must be performed to determine which types should be included each year.

Description of Condition

In the past few years, we have reported that the Department of Social and Health Services is using millions of Medicaid dollars to pay providers who are ineligible for these funds and to pay for services to ineligible clients and/or for services that are unallowable. As part of our audit for fiscal year 2004, we again attempted to determine if clients and providers met allowability and eligibility requirements. After assessing risk, we determined the following areas to be of highest risk for lack of compliance:

- Services performed after the date of a client's death.
- Non-emergency services for undocumented aliens.
- Services for clients who did not meet income standards for the portion of Medicaid known in Washington as Basic Health Plus.
- Medical and surgical procedures that did not appear to be within the scope of services as described in the Washington Medicaid State Plan.

We determined that a review of each of these issues would be sufficient to enable us to provide an opinion on compliance with Medicaid allowability and eligibility requirements. As part of our evaluation of controls and compliance, we interviewed or attempted to interview staff members involved in the process and selected or attempted to select paid claims for further analysis.

In addition, as we evaluated other compliance areas, we found other issues impacting either allowability or eligibility, such as:

- Assistance funds paid to rural public hospital districts through the Proshare Program.

- Payments to nursing homes.
- Costs of drug inventories at four residential habilitation centers for the developmentally disabled.

We encountered numerous difficulties with obtaining access to information for this audit. They were:

The Department of Social and Health Services and the Health Care Authority

- Some of the information and data we requested was either not provided or provided only after our field work had ended.
- Agency personnel attempted to thwart particular audit procedures by questioning our authority to either expand the scope of our audit or to obtain certain information.

The Department of Social and Health Services

- The Department altered information related to sample transactions while we were attempting to complete our review.
- We were unable to obtain original data directly from the source. Much of the information we requested was filtered through the Medical Assistance Administration's Business and Finance Division, the audit liaison for the Medicaid audit.
- In some instances, we were unable to independently interview line staff without the presence of management or without management's selection of the employees to be interviewed.
- Staff members informed us that they had to obtain permission from management prior to speaking with auditors. During our review of the allowability of certain medical procedures and of procedures provided to undocumented aliens, we were never granted permission to speak with the medical consultants who had approval authority.
- After our review of pharmaceutical inventory was completed and the Department had reviewed our results, the Department stated it had given us the wrong data for two of the four residential habilitation centers.

In addition to information access problems, we also encountered external impairments at the Department of Social and Health Services. Auditors of the Medicaid Program were subjected to undue criticism of their integrity, independence, competence, objectivity, and knowledge. These charges against audit staff were made both in person and through e-mail, and we believe they were intended to deter us from completing our audit.

Cause of Condition

The audit liaison systems that the Department and the Authority set up this year prevented us from obtaining the information and conducting the procedures necessary to complete our audit of allowability and eligibility according to Generally Accepted Auditing Standards and in compliance with federal auditing regulations.

The Department did not ensure that the pharmaceutical data it initially provided to us was accurate and complete.

Effect of Condition

Because of the agency-imposed scope limitations and the external impairments to the auditors, the State Auditor's Office was unable to assess controls and independently evaluate whether we had obtained reasonable assurance that the state is complying with the requirements of the four areas we determined would be sufficient to provide an opinion on allowability and eligibility or with other areas that also impacted costs.

Therefore, we are disclaiming our opinion on compliance as it relates to allowability and eligibility of all Medicaid costs. We have estimated the payments attributable to such claims for the period July 1, 2003 through June 30, 2004 to be more than $6 billion. Approximately 50 percent of these costs were paid with federal Medicaid funds and the other half with state funds.

Recommendations

We recommend the Department of Social and Health Services and the Health Care Authority:

- Ensure that the State Auditor's Office has timely access to the information and resources it needs to complete its audit.

- Ensure managers understand the role of independent audits in reporting on compliance with applicable laws and regulations, when continued receipt of funds depends on such compliance.

- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid must be reimbursed as a result of this disclaimer.

Department of Social and Health Service's Response

The Department strongly disagrees with this finding, which is not supported by Government Auditing Standards. The department rejects the contention that its staff deliberately interfered with auditors and their work. However, poor communications, unreasonable timelines and the State Auditor's Office's (SAO) unwillingness to follow clear procedures prevented agency staff from complying with all of the auditors' requests for data and information. These are all areas that need to be resolved before the next audit.

- *The SAO is attempting to disclaim the entire Medicaid program as it relates to allowability and eligibility of all Medicaid costs. But it is inconsistent with auditing standards to disclaim an entire program while rendering specific opinions on specific audit areas.*

- *The Department also questions methods used to project payments in various areas within the Medicaid audit. The auditor has reviewed a "selected valid sample." Whether or not the tests were random, the auditor used nonstatistical sampling methods instead of statistical sampling to project or extrapolate results from sampling. The AICPA's Audit Guide states, "Any sampling procedure that does not measure the risk is a non-statistical sampling procedure…" A New York State CPA Journal addresses non-statistical sampling at this web page: http://www.nysscpa.org/cpajournal/2004/504/essentials/ p30.htm. Without following this rule, the auditor is in the position of relying on judgment or intuition – instead of available statistical theory -- in interpreting the results of a sampling procedure. As stated in CPA Journal, "Such a view is potentially hazardous, because the auditor is permitted to ignore facts that are readily discernable to any practitioner, or legal adversary, who is knowledgeable in the application of statistical methodology."*

- *This year's audit is the culmination of many difficulties that the Department has experienced with this audit team:*

    1. *The Medicaid entrance interview was restricted to the program level vs. specific audit areas, and follow-up meetings with the team did not clarify these details. This vagueness failed to communicate SAO's actual objectives and needs. When DSHS staff attempted to clarify those points, they were perceived as questioning the auditor's purview. Additionally, the SAO continued to schedule entrance interviews in early October, including audit scope expansion, even though the due date for completion of field work was October 15. Overall, the Department was not given reliable timelines for individual audit areas. This made it impossible to dedicate the resources necessary for timely and accurate responses to all of SAO's requests.*

2. *The SAO frequently asked Medical Assistance Administration (MAA) to review large volumes of data without identifying audit criteria or other necessary information -- such as Internal Control Numbers (ICN) or Patient Identification Codes (PIC) -- that would have expedited the review. Complicating this problem, the SAO was largely inflexible in granting additional time when these conflicts emerged. In several instances, the SAO decided time had run out and that MAA's review and feedback could not be used. Department attempts to seek clarification also were often perceived as questioning SAO's methodology or decisions.*
3. *The scope of the audits for both ProShare and Basic Health Plus were expanded without notification of the Medicaid audit liaison. The SAO only confirmed these decisions after the liaison made several attempts to discover whether the scope had been changed. SAO indicated to the Department that it should not question SAO's authority.*
4. *The SAO also openly expressed its suspicion of certain DSHS employees and accused them of tampering with data simply to sabotage the audit. In one audit area, SAO alleged that MAA's routine correction of errors (such as incorrect SSNs) to ensure payment accuracy was an attempt to invalidate SAO's testing. In another area, the SAO specifically requested that MAA's audit liaison not handle data related to Alien Emergency Medical (AEM). Although this request was honored, the draft finding still concluded that the data was somehow "poisoned" and was therefore not usable.*
5. *Audit findings have been based on misunderstandings of federal rules, and SAO resisted changing those findings even when confronted with correct information by the federal agencies involved. For example, MAA has obtained written information from the federal Centers for Medicare and Medicaid Services (CMS) that the federal program accepts MAA's methodology on the Nursing Home ProShare payment of $122 million. In addition, the ProShare payments have been audited by both CMS and the Office of the Inspector General (OIG) in prior years, and corrections indicated by those audits have been implemented. The SAO has refused to accept CMS' endorsement and disclaims the entire $122 million.*
6. *In some cases, auditors' conversations with line staff who were not authoritative or who possessed incomplete knowledge resulted in findings based on flawed information. But the Department's effort to correct those findings was rejected by auditors who were not willing to reopen their work papers. In several audit areas – Escheated Warrants, DME and Payer of Last Resort – SAO asked MAA to review test data or assertions that were based on incomplete or incorrect data. When MAA responded with new and relevant information, SAO took the position that work papers had been finalized and cannot be changed.*
7. *To help prevent misunderstandings that have interfered with earlier audits, the Department this year appointed an overall audit liaison as well as single points of contact for each audit area with the understanding that both the audit liaison and the points of contact would be notified by SAO when it filed a request for data or additional information. SAO repeatedly failed to comply with these requirements.*
8. *The audit process was hampered by communication gaps on the part of the auditors. In one instance, SAO decided that the Deputy Assistant Secretary's presence at an entrance audit (Provider Health and Safety Surveys for Nursing Homes) "hampered external testing." However, SAO did not cite this at the time of the meeting or in its immediate aftermath. The Department was only notified of this decision much later during a monthly audit update and only then because MAA staff asked for clarification. The SAO dropped this cause of condition but only after strenuous objection by the Department. Another example is when SAO decided to expand the scope of both the ProShare and Basic Health Plan audits but refused to acknowledge or confirm it despite three separate requests for clarification by MAA.*

Auditor's Concluding Remarks

The state receives more than $3 billion dollars annually in federal funds for the Medicaid Program. These funds are paid to the state on the condition that it adheres to the compliance requirements that govern Medicaid. One of these requirements is that the program be audited every year and that instances of material noncompliance are reported. The disclaimer is the result of our audit of the program for 2003-04. We included the results of whatever we were able to audit to demonstrate we attempted to do the work as the federal government requires.

Eligibility and allowability are compliance areas that must be audited to determine whether the majority of Medicaid funds are spent in accordance with program requirements. When we did not receive the data we needed to perform our tests in these crucial areas, we were unable to apply all the procedures required to form a conclusion that would sustain an opinion of reasonable assurance. Our decision to disclaim on the audit of the Medicaid Program is in compliance with the auditing standards of the American Institute of Certified Public Accountants and Government Auditing Standards.

It has come to our attention the Department represented in statement 9 of the 2004 *Agency Federal Assistance Certification*, signed by Department management on December 9, 2004, that:

> "We have made available all documentation related to compliance requirements, including information related to federal programs financial reports and claims for advances and reimbursements,"...

This certification is contrary to our opinion.

Our audit strategies, tests and conclusions are governed by the *Statements on Auditing Standards* (SAS) circulated by the American Institute of Certified Public Accountants. All auditors performing governmental audits must follow these standards. The third standard of fieldwork states that sufficient competent evidential matter must be gathered in order to form the basis of an opinion. Examining documentation for every transaction is costly and time-consuming. Most audits do not require that amount of evidence, and it would be an unlikely scenario for Medicaid, which generates over 30 million transactions a year. To obtain evidence that meets the standards, auditors will frequently use sampling techniques. The guidelines for these procedures are outlined in SAS-39.

SAS-39 endorses both a nonstatistical approach and a statistical approach and recognizes that judgment is an integral part of either method when it states:

> "There are two general approaches to audit sampling: Nonstatistical and statistical. Both approaches require that the auditor use professional judgment in planning, performing, and evaluating a sample and in relating the evidential matter produced by the sample to other evidential matter when forming a conclusion about the related account balance or class of transactions. The guidance in this Statement applies equally to nonstatistical and statistical sampling."

With respect to the difficulties that the Department states it experienced with the auditors:

1. During our Medicaid entrance conference with the Secretary of the Department, we went over the compliance areas we are required to audit. We held additional entrance conferences with those involved in each specific area and explained the nature, timing and extent of planned testing. Additionally, we conducted monthly update meetings with the Department's official liaison, but other staff, who may have been able to provide relevant information often were not present.

   In order to preserve the independence of an audit, testing strategies are never given to an auditee prior to obtaining data. If an auditee is aware of testing strategies, the data could be altered or destroyed, and we could not rely on the results of those tests to form an opinion on compliance.

2. The results of our testing were provided to Department staff in electronic format. We also encouraged the Department to review the paper documents that supported our position. It never availed itself of the opportunity to do the latter. Instead, the Department used its resources to retest our samples and selections. Department staff provided us only with percentages related to their results; these percentages were always at variance with ours. We were never given any backup documentation to support their results or to refute ours.

   Additional time to provide information was always given to the Department when our timelines could accommodate those requests. We used significant resources attempting to obtain required data. The Department was repeatedly informed during update meetings that if we did not receive data in a timely fashion, our procedures would be delayed, resulting in less time for the Department to review our exceptions.

3. If we saw an area of risk that we had not previously anticipated, we expanded our scope. We did this in an effort to obtain sufficient competent evidence to sustain a reasonable basis for an opinion, as required by audit fieldwork standards.

4. When we required corroboration of management's representations, we met resistance. The General Standard 3.33 for governmental audits speaks to professional judgment. It states:

> Professional judgment should be used in planning and performing audits and attestation engagements and in reporting the results.

General Standard 3.36 continues:

> Professional judgment requires auditors to exercise professional skepticism, which is an attitude that includes a questioning mind and a critical assessment of evidence.

Requesting corroboration or requiring that evidence come from the primary source is a fundamental audit principle, as is the application of professional skepticism.

The Department's statement that we used the word "poisoned" when referring to some data is untrue.

5. Our findings are reviewed by legal staff before an opinion on compliance is made. We do understand, however, that the Department disagrees with some of those legal interpretations of state law and federal regulations.

The Department stated it received written approval from the Centers for Medicare and Medicaid Services for its method of calculating the Proshare payment. We have requested a copy of this approval but have not received it. Also, this method is not included in the State Plan. The federal Department of Health and Human Services Office of Inspector General stated that, if the methodology for the calculation of the Proshare payment is not in the State Plan, it is an unallowable cost.

6. The Department stated above that line staff members were not authoritative or did not possess complete knowledge of the system. We agree that transaction errors and noncompliance sometimes occurred due to employees' lack of knowledge.

The Department stated that for three of the audit areas tested – Escheated Warrants, Durable Medical Equipment and Payer of Last Resort – we rejected new and relevant information presented to us after our field work was completed. However, the Department presented no such information. In fact, it concurred with our findings for Escheated Warrants and Payer of Last Resort in findings M04-17 and M04-19.

Additional evidence for Durable Medical Equipment was presented to us before we completed our testing. Some of the information was sufficient to rescind some of our exceptions, which we did.

7. We believe that we can work with the Department to improve the liaison system to ensure that we receive the information we need to complete an independent audit.

8. See item 7 above.

Health Care Authority's Response

The Health Care Authority (HCA) is very disappointed that it was never informed by the State Auditor's Office of the existence of this additional finding and not given the opportunity to respond. We only became aware of this finding on December 14, 2004, when we saw it posted on the DSHS website. As stated in finding # 6, we categorically reject the notion that HCA or its personnel did not provide requested information or that we attempted to "thwart" any audit procedure. We were never privy to any audit procedures at other agencies and we provided exactly the data requested of us.

We would also like to clarify the Cause of Condition statement in this finding. First, the HCA did not change any audit liaison system at our agency. We have used the same process for a number of years. During this time our agency audits have gone smoothly, ensuring that the auditors are provided with access to personnel and documents necessary to complete their audit efficiently and that our management is kept informed of the audit process and results. The SAO has never communicated to us a need to change our internal agency liaison procedures.

Secondly, we communicated to the state auditors in May of 2004 that DSHS did invoke its rights under its agreement with HCA to ensure we provided DSHS data to the auditors. The data that fell under the contract was requested by the auditors on May 13, 2004. That same day DSHS requested that HCA release the data to the auditor. It was provided to the auditor on May 27, 2004. The auditors made a second request for additional HCA data on June 23, 2004. This data was also provided and is discussed in our response to finding #6.

Auditor's Concluding Remarks

We have carefully reviewed the Health Care Authority's response and reaffirm our finding. At a meeting held with the acting director on November 19, 2004, we brought schedules showing the information received in the prior year that was requested and not provided during the current audit period. These schedules confirmed that the information we requested did exist. Therefore, we found there was no reason to amend the finding. We informed the acting director at this meeting that there would be a finding.

Applicable Laws and Regulations

RCW 43.09.310 states in part:

> The state auditor shall annually audit the statewide combined financial statements prepared by the office of financial management and make post-audits of state agencies. Post-audits of state agencies shall be made at such periodic intervals as is determine by the state auditor . . . .

American Institute of Certified Public Accountants, Statement of Position 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards*, Paragraphs 10.43 and 10.44 state, in part:

> The auditor is able to express on an unqualified opinion only if he or she has been able to apply all the procedures the auditor considers necessary in the circumstances. Restrictions on the scope of the audit – whether imposed by the client or by circumstances such as the timing of the auditor's work, an inability to obtain sufficient competent evidential matter, or an inadequacy of the accounting records – may require auditors to qualify their opinion or to disclaim an opinion.
>
> When restrictions that significantly limit the scope of the audit are imposed by the client, the auditor generally should disclaim an opinion on compliance.

The American Institute of Certified Public Accountants' *Codification of Statements on Auditing Standards*, at AU Section 311.05, states in part:

> . . . The form of the audit program and the extent of its detail will vary with the circumstances. In developing the program, the auditor should be guided by the results of the planning considerations and procedures. As the audit progresses, changed conditions may make it necessary to modify planned audit procedures.

The *Codification of Statements on Auditing Standards* also states in part at AU Section 326.01:

> Most of the independent auditor's work in forming his or her opinion on financial statements consists of obtaining and evaluating evidential matter concerning the assertions in such financial statements. The measure of the validity of such evidence for audit purposes lies in the judgment of the auditor; . . . Evidential matter varies substantially in its influence on the auditor as he or she

> develops an opinion with respect to financial statements under audit. The pertinence of the evidence, its objectivity, its timeliness, and the existence of other evidential matter corroborating the conclusions to which it leads all bear on its competence.

The Codification's AU Section 326.21 continues:

> To be competent, evidence, regardless of its form, must be both valid and relevant. The validity of evidential matter is so dependent on the circumstances under which it is obtained that generalizations about the reliability of various kinds of evidence are subject to important exceptions.

AU Section 326.25 states in part:

> . . . In developing his or her opinion, the auditor should consider relevant evidential matter regardless of whether it appears to corroborate or to contradict the assertions in the financial statements. To the extent the auditor remains in substantial doubt about any assertion of material significance, he or she must refrain from forming an opinion until he or she has obtained sufficient competent evidential matter to remove such substantial doubt or the auditor must express a qualified opinion or a disclaimer of opinion.

Government Auditing Standards ("Yellow Book"), Sections 3.33-3.89 are also applicable to these issues, since these sections discuss the use of auditor judgment. As described here, the general standard related to professional judgment is:

> Professional judgment should be used in planning and performing audits and attestation engagements and in reporting the results.

The Yellow Book, Section 4.03 c, states one of the field work standards is:

> Sufficient, competent, and relevant evidence is to be obtained to provide a reasonable basis for the auditors' findings and conclusions.

OMB Circular A-133, which sets out requirements for audits of federal programs, states in Section .505:

> . . . The auditor's report(s) shall state that the audit was conducted in accordance with this part and include the following:
>
> (c) A report on compliance with laws, regulations and the provisions of contracts or grants agreements, noncompliance with which could have a material effect on the financial statements. This report shall also include an opinion (or disclaimer of opinion) as to whether the auditee complied with laws, regulations, and the provisions of contracts or grant agreements which could have a direct and material effect on each major program . . . .

Section .510 a.2 is also relevant:

> Material noncompliance with the provisions of laws, regulations, contracts, or grant agreements related to a major program. The auditor's determination of whether a noncompliance with the provisions of laws, regulations, contracts, or grant agreements is material for the purpose of reporting an audit finding is <u>in relation to a type of compliance requirement for a major program</u> (Emphasis added) or an audit objective identified in the compliance supplement.

The Circular A-133 Compliance Supplement states:

Applicability

General
Auditors shall consider this Supplement and the referenced laws, regulations, and OMB Circulars (whether codified by Federal agencies implementing the Circulars in agency regulations or implemented by other means) in determining the compliance requirements that could have a direct and material effect on the programs included herein. That is, use of this Supplement is mandatory…

Safe Harbor Status
Because the suggested audit procedures were written to be able to apply to many different programs administered by many different entities, they are necessarily general in nature. Auditor judgment will be necessary to determine whether the suggested audit procedures are sufficient to achieve the stated audit objectives or whether additional or alternative audit procedures are needed. (Emphasis added) Therefore, the auditor should **not** consider this Supplement to be a "safe harbor" for identifying the audit procedures to apply in a particular engagement.

Responsibility for Other Requirements
Although the focus of this Supplement is on compliance requirements that could have a direct and material effect on a major program, auditors also have responsibility under *Generally Accepted Government Auditing Standards* (GAGAS) for other requirements when specific information comes to the auditors' attention that provides evidence concerning the existence of possible noncompliance that could have a material indirect effect on a major program (Emphasis added).

04-02 The Department of Social and Health Services, Medical Assistance Administration, did not provide the State Auditor's Office sufficient, reliable and timely records for our audit to determine if payments through the *Medicaid Management Information System* are made only for services provided before a client's date of death.

Background

During our 2002 audit, we analyzed the validity of Medicaid clients' Social Security numbers as well as claims that could have been paid after a person had died. During that audit, we sampled 639 Medicaid recipients and found that 50 percent had issues related to the validity of the client's Social Security number. For example, we found invalid Social Security numbers, Medicaid payments for services rendered after individuals had died, and clients who were using a Social Security number that was assigned to a deceased person. Factors contributing to these conditions included Department staff not heeding or investigating alerts sent by the Social Security Administration; the Department's reliance on family members to voluntarily inform it of a client's death; and computer errors that occurred when client data was transmitted between the Department's client eligibility system and the Medical Management Information System.

During our 2003 audit, we attempted to determine if the Department had established controls that would ensure that only claimants with valid Social Security numbers were enrolled in the program and that people who were deceased were promptly removed from Medicaid eligibility. We found the Department did not have effective procedures that would enable all Community Service Offices to be notified of a client's death in a consistent and timely manner. Additionally, the Department and the Department of Health did not communicate for the purpose of obtaining notice of client deaths. We also found that internal controls to ensure the validity of Social Security numbers were inconsistent from one Community Service Offices to another.

Also during that audit, the Department did not provide us with reliable records in a timely manner. As a result we were unable to determine which unallowable payments were due to inadequate controls. We issued a report stating we could not determine whether payments were valid and questioned over $288 million dollars in costs.

Description of Condition

For the fiscal year 2004 audit, we attempted, with the limited information made available to us by Department staff, to evaluate internal controls and compliance with federal regulations. The testing we planned to perform was for the period January 1, 2003 through December 31, 2003. We attempted to determine amounts paid through the Medicaid Management Information System for services provided after a client's death or services provided to persons using the Social Security number of a deceased person. From a total of 2,632 clients for whom these types of payments appeared to have been made, we obtained a valid sample of 188 clients. We encountered several difficulties with obtaining access to information for this audit, as follows:

- The U.S. Social Security Administration would not permit us independent access to the State Online Query (SOLQ), which is a system that can verify Social Security numbers. This forced us to depend on the Department, which does have access, to perform all of our Social Security number verifications. As a result, the Department was aware of the transactions being tested. When errors were found, the Department made alterations to the sample data in its computer systems that prevented us from completing our tests as planned. This action invalidated our sample and prohibited us from assessing compliance with reasonable assurance and reaching a conclusion. We were unable to determine if data originally given to us was faulty or if the current data was faulty.

- In some cases, SOLQ data provided a date of death, but the Administration stated the client was still alive because the state Department of Health had no death certificate. However, we were unable to obtain independent access to death certificate information to confirm this statement. During our previous audit, the Department of Health reported that we would be charged at least $15 for each death certificate. Thus, the information was not available to us without substantial cost. The Administration does have a link to the Department of Health data base, with free unlimited access to this information. However, the Administration would not provide us with a computer terminal that would have enabled us to have independent access to this data. The Administration offered this data but would only provide it to us if its

staff members performed the work and reported the results to us. Thus, we could not obtain this information independently.

We were able to obtain some information about the services we selected. From the review we managed to perform, we found 158 potential exceptions as follows:

- Use of deceased relative's Social Security number: 67 exceptions, or 35.6 percent, with estimated actual and projected costs of $2,407,151.

- Apparent identity theft of a deceased unrelated person's Social Security number: 50 exceptions, or 26.6 percent, with estimated projected costs of $1,418,814. There is a high risk that the $703,619 of actual identified costs are the result of fraudulent transactions.

- Data entry error by Department: 17 exceptions, or 9 percent, with estimated actual and projected costs of $511,342.

- Apparent provider fraud: 22 exceptions, or 11.7 percent, with estimated projected costs of $301,998. There is a high risk that the $143,485 of actual identified costs are the result of fraudulent transactions.

- Apparent identity theft of a living person's name and/or Social Security number: 2 exceptions, or 1.1 percent, with estimated projected costs of $31,127. There is a high risk that the $12,205 of actual identified costs are the result of fraudulent transactions.

The total estimate of actual and projected costs for all of these services combined was $4,670,432. However, had we been able to obtain the information we needed independently, actual and projected costs may have been higher.

Cause of Condition

The audit liaison system the Administration set up this year prevented us from obtaining the information and conducting the procedures necessary to complete our audit according to Generally Accepted Auditing Standards and in compliance with federal auditing regulations.

However, with regard to the results of the procedures we could complete, we believe the causes to be:

- Social Security numbers are not consistently verified prior to admitting clients into the Medicaid program. The Department has the capability of verifying the validity of a Social Security number through SOLQ at the time of application. This control is not always used by staff members because they are not consistently trained and because of lack of management oversight. Workers are able to clear alerts notifying them that numbers belong to people who have died.

- The Administration is largely dependent on the provider or family members to voluntarily report a current client's death.

- There are known problems with the transfer of some data between Departmental data systems.

Effect of Condition

Because of an agency-imposed scope limitation, the State Auditor's Office did not have access to resources that would have allowed us to assess controls and to independently evaluate whether the Department was complying with Medicaid requirements in this area. Therefore, we cannot provide an opinion on compliance regarding allowable costs and eligibility of clients for Medicaid claims paid for services provided after the date of a client's death.

We estimate the cost of payments for such claims for the period of January 1, 2003 through December 31, 2003 to be at least $4,670,432 but they may be as high as $6,017,824. Due to timing issues, we were unable to determine how much was paid in claims for the fiscal year period, July 1, 2003 through June 30, 2004; however, we believe the calendar year expenditures are an accurate approximation of the fiscal year expenditures. Federal Medicaid funds

provided half of the payment amount; state funds provided the other half. The total amount is included in the overall Program disclaimer.

In addition, the Medicaid program is unnecessarily susceptible to loss or misappropriation because of the Administration's inability to identify deceased clients in a timely manner.

Recommendations

With respect to recommendations for compliance with audit requirements, we recommend the Department:

- Ensure that the State Auditor's Office has timely access to the information and resources it needs to complete its audit.
- Ensure managers understand the role of independent audits in reporting on compliance with applicable laws and regulations when a provision of continued receipt of those funds is contingent on compliance.
- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this disclaimer.

With respect to recommendations for strengthening controls that would reduce the possibility of fraud and noncompliance with federal regulations, we recommend the Department develop and follow procedures that:

- Require staff to verify Social Security numbers for all Medicaid clients.
- Require staff to heed alerts sent by the Social Security Administration.
- Make it impossible for staff to delete alerts without management's approval and/or knowledge.
- Resolve the computer interface problems between its data systems.
- Establish procedures with the Department of Health that will provide notification of clients' deaths in a timely manner.
- Ensure staff members understand the new state law (Revised Code of Washington 9.35.020), which took effect July 1, 2004, and which defines identity theft in the first degree as the use of false identification to obtain anything of value in an aggregate of $1,500.

In addition, we recommend the Administration forward the instances of apparent identity theft and provider fraud to its own Post-Payment Review Office or to the appropriate legal authorities.

Department's Response

The Department does not concur with this finding.

- *The Department made every effort to provide timely access to accurate data/information, and to assist SAO by performing Social Security Number (SSN) verifications as requested. MAA communicated to SAO on several occasions its willingness to provide immediate SAO access to a Department workstation for SAO use in the validation of data/information. But the Department is not the owner of either the State Online Query System (SOLQ) or Department of Health (DOH) death certificate data. In order for SAO staff to use that workstation themselves, they first had to obtain a data access agreement. When SAO was unable to obtain that agreement, Department staff were assigned to assist SAO by performing SSN verification lookups. The Department is unable to understand why MAA staff verification of requested records, looked up and printed in the presence of SAO staff, negates the independent quality of the audit.*
- *The Department disagrees with the assertion that corrections to SSNs during the audit time period invalidate the sample records under review. The claims data provided to SAO was a "point in time"*

extract. Both MAA and Economic Services Administration (ESA) have employees whose daily job duties include correction of SSN errors. This activity did not impact SAO's ability to test, nor does a data change alter the outcome of testing.

- *The Department recognizes that there are problems with the interface between the Automated Client Eligibility System (ACES) and the Medicaid Management Information System (MMIS). Department staff continues to assess, prioritize and resolve these issues as they are identified. Implementation of an interface change in the current environment would be a complex and lengthy process. However, the problem will be better resolved within the next few years with the procurement of a new MMIS, which includes a complete assessment of the ACES/MMIS interface. A Cross-Agency Workgroup has been established to review and assess interface issues, provide recommendations, and work with the vendor of the new MMIS to develop the new interface.*

  In addition, the Department is a stakeholder in a DOH initiative that will provide an on-line application to access DOH death data. DSHS will partner with DOH to develop an interface to that system when it is available. However, DOH will still remain dependent upon counties for receipt of death data, resulting in a lag in DOH receipt of the information.

- *This timing issue means the Department will have to continue post-pay review activities and recoupment of claims for deceased clients. Of the 188 clients included in the data file sent by SAO, MAA staff validated that 17 (9.04%) were deceased. The DSHS Payment Review Program's algorithm that utilizes quarterly DOH death data identified and recouped appropriate claims for all but one of the clients. Following Department review, a death date for that client was also entered into the MMIS, and appropriate claims recouped. (Detailed data review is available upon request)*

- *The remainder of the clients were not deceased. The flawed conclusion was apparently the result of either an error in the death date contained in the federal database utilized by SAO or the association of the SSN of a deceased individual with a living Medicaid client. The Department is already working to better identify these conditions and prevent them.*

  1. *There are instances where the SSN of a client's spouse is correctly entered into ACES, since client eligibility and income verification are based on the spouse's SSN. In these cases, the Health Insurance Claim number in ACES should include a suffix code that identifies that the client's eligibility is dependent upon the spouse's income.*
  2. *In response to Audit Finding No. 03-04, the Department convened a Workgroup to review options to enhance the already established procedures related to verification of Social Security Numbers, thus improving the accuracy of SSN in ACES. The Corrective Action Plan for that finding addresses those issues. Newly established automated verification of SSN for each ACES entry is scheduled to be implemented in February 2005.*

Auditor's Concluding Remarks

We reaffirm that the Department's actions prevented us from achieving the goal of *Government Auditing Standards*, Field Work Standards, 4.03 (c) which states:

> Sufficient competent evidential matter is to be obtained through inspection, observation, inquiries, and confirmations to afford a reasonable basis for an opinion regarding the financial statements under audit.

In the first year of reviewing this area, the Department gave us independent access to its computers, including the State On-line Query system. Our confidentiality agreement with the Department was sufficient. Data access agreements with other agencies or the federal government were not required. With each subsequent year, our access to the Department's systems has diminished.

The audit liaison system, as actually used by the Department, hindered our access to data and obstructed our contact with line staff. Additionally, the audit liaison system attempted to force us to rely on the Department's representations as to the existence or accuracy of evidence. In effect, the Department was attempting to perform the work of the auditor, instead of allowing the auditors to perform an independent audit and reach a valid conclusion.

Our audit also was compromised by the corrections the Department made to erroneous Social Security numbers in ACES, a system which does not identify what changes were made or when. We understand the Department's responsibility to correct errors, and we requested paper documentation acknowledging the changes to Social Security numbers and client dates of death, along with the dates the changes were made. The Department did not provide such documentation; therefore, the integrity of the data was compromised and we were unable to reach a conclusion.

After obtaining our preliminary results, we asked the Department for any additional documented specific information for each transaction that might lead us to a conclusion about the validity of the transaction. Such information was never provided to us. In addition, the Department did not notify us, prior to the response to this finding that it was making an effort toward recoupment of some of the costs we reviewed.

After reviewing the work that we had performed, we judged that we could not use it to base our opinion on compliance. We did not have reasonable assurance that the Department was in compliance, and the risk of audit failure was high due to the numerous impairments we encountered. Although we are disclaiming, we are presenting the results of our review in this finding to show our attempts to test compliance for allowability and eligibility for the Medicaid Program, as the federal government requires, and also to disclose what we were able to learn.

Applicable Laws and Regulations

Disclaimer

RCW 43.09.310 states in part:

> . . . The state auditor shall annually audit the statewide combined financial statements prepared by the office of financial management and make post-audits of state agencies. Post-audits of state agencies shall be made at such periodic intervals as is determined by the state auditor . . . .

The American Institute of Certified Public Accountants, Statement of Position 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards*, Paragraph 10.43 and 10.44 states, in part:

> The auditor is able to express on an unqualified opinion only if he or she has been able to apply all the procedures the auditor considers necessary in the circumstances. Restrictions on the scope of the audit - whether imposed by the client or by circumstances such as the timing of the auditor's work, an inability to obtain sufficient competent evidential matter, or an inadequacy of the accounting records - may require auditors to qualify their opinion or to disclaim an opinion.
>
> When restrictions that significantly limit the scope of the audit are imposed by the client, the auditor generally should disclaim an opinion on compliance.

Compliance

The Code of Federal Regulations is explicit regarding obtaining and verifying Social Security numbers as a condition of Medicaid eligibility. 42 CFR 435.910 (a) specifically states in part:

> The agency must require, as a condition of eligibility that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers . . . .

42 CFR 435.910 (g) states:

> The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

If a Medicaid applicant cannot remember or has not been issued a Social Security number, 42 CFR 435.910 (e) (1-3) states that the agency must:

(1) Assist the applicant in completing an application for an SSN;

(2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and

(3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

42 CFR 435.916 (a) states in part:

> The agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months . . .

42 CFR 435.920 (a-c) states:

(a) In re-determining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.

(b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of 435.910.

If the agency initially established eligibility without verification of the Social Security number, 42 CFR 435.920 (c) requires:

> For any recipient whose SSN was established as part of the case record without evidence required under the SSN regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

The Medicaid State Plan incorporates the above references as applicable to Washington State's coverage and eligibility criteria when it states the following:

> The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

RCW 9.35.020 states in part:

(1) No person may knowingly obtain, possess, use, or transfer a means of identification or financial information of another person, living or dead, with the intent to commit, or to aid or abet, any crime.

(2) Violation of this section when the accused or an accomplice uses the victim’s means of identification or financial information and obtains an aggregate total of credit, money, goods, services, or anything else of value in excess of one thousand five hundred dollars in value shall constitute identity theft in the first degree . . . .

04-03 The Department of Social and Health Services paid providers with Medicaid funds through the *Social Services Payment System* for services provided to clients using Social Security numbers belonging to deceased persons.

Background

While most Department of Social and Health Services payments to providers from Medicaid funds are processed through the Medicaid Management Information System, some are processed through the Social Services Payment System (SSPS). Medicaid program services paid through SSPS include the Community Options Program Entry System, Supported Living Services, and Medicaid Personal Care. Eligibility for these Medicaid programs is based on many factors; however, a valid Social Security number is required, even for children.

Description of Condition

As a result of our review of SSPS records, we found 613 instances in which the name of the client served did not match the name of the deceased person, even though the Social Security number was the same. These exceptions indicate possible identity theft of a deceased person and potential noncompliance with Medicaid requirements. Based on this analysis, we determined this area to be high risk and expanded our audit.

We obtained a valid sample, randomly selecting 225 clients out of the 613. We found 155 potential exceptions with related actual and projected questioned costs of at least $1,553,627.

Of the 155 tested, we found:

- Use of a deceased relative's Social Security number: 92 exceptions, or 40.9 percent, with associated actual and projected costs of at least $1,063,508.

- Apparent identity theft of a deceased unrelated person's Social Security number: 23 exceptions, or 10.2 percent, with associated actual and projected costs of at least $281,702.

- Data entry error by the Department: 40 exceptions, or 17.8 percent, with associated actual and projected costs of at least $208,417.

As part of our review, but not as part of the valid sample, we also found six clients with names similar to those of deceased persons, but without matching birth dates. This again indicates the possibility that the client used a deceased relative's Social Security number. These costs totaled $78,278.

We shared our detailed results with the Department and requested any additional information it had regarding the exceptions. We received no response from the Department other than a statement it only agreed with two of the exceptions we found and therefore our data was inaccurate. However, no documentation was provided to confirm this statement.

Cause of Condition

The Department has not made the verification of Social Security numbers a high priority.

Effect of Condition

The Medicaid program is unnecessarily susceptible to loss because the Department cannot identify in a timely manner clients using Social Security numbers of deceased persons. The total actual and projected payments as a result of this finding are at least $1,631,905 and are included in the overall Program disclaimer. Half of this amount, or $815,953, was provided with federal funds and the remainder with state funds.

Recommendations

We recommend the Department:

- Require staff to verify Social Security numbers for all Medicaid clients.
- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to Medicaid must be reimbursed.
- Ensure staff members understand the new state law (Revised Code of Washington 9.35.020), which took effect July 1, 2004, and which defines identity theft in the first degree as the use of false identification to obtain anything of value in an aggregate of $1,500.

In addition, we recommend the Department forward the instances of apparent identity theft to its own Post-Payment Review Office or to the appropriate legal authorities.

Department's Response

The Department does not concur with these conclusions or the methodology used.

- ***Require staff to verify Social Security numbers for all Medicaid clients.***

  WAC 388-476-0005 defines the Department's current Social Security Number (SSN) requirements for medical eligibility, and can be found in the DSHS EA-Z Manual at http://www1.dshs.wa.gov/esa/EAZManual/Sections/SSN.htm. Section 3 states, "Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration (SSA). However, a person who does not comply with these requirements is not eligible for assistance." Verification procedures are described under the section titled "Clarifying Information." SSNs are automatically verified through a cross-match with the SSA Numident file, once the data is entered into the Automated Client Eligibility System (ACES). Section 3 under "Clarifying Information" states: "If a current and valid SSN is not available, the department is responsible to assist a client in making an application for an SSN."

  SSN discrepancies in Numident generate alerts as described in the ACES User Manual at http://www1.dshs.wa.gov/esa/acesman/Sections/alerts/alert_188.htm. On the site, alert_253 describes how workers are notified when there is an SSN discrepancy in the State Data Exchange (SDX), Beneficiary Data Exchange System (BENDEX) or Numident. Furthermore, when the Home and Community Services Quality Assurance Unit reviews client files to confirm financial eligibility, they check to see that the SSN recorded in the Social Services Payment System (SSPS) is the same as the SSN recorded in ACES. They report discrepancies, using ACES as the correct record of the SSN.

- ***Work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to Medicaid must be reimbursed.***

  1) Of the 150 clients provided to us for review, 43 percent now have a corrected SSN coded on their SSPS authorization. This indicates that a large number of the discrepancies may be due to keying errors. 2) 79 of the clients listed on the SAO reports were using the SSN of a deceased related person. Of these, 70 are females born before 1934. It appears that widows are still using their deceased husband's SSN, since it was common in the early part of the last century for women not to have their own SSN. We do not believe that this is indicative of identify theft or fraud.

  ADSA invested time and resources in the department's Payment Review Program (PRP) to develop a payment-after-death algorithm to identify potentially incorrect payments following the death of a client. This algorithm is re-run quarterly, and findings are referred to the Office of Financial Recovery or the Medicaid Fraud Control Unit for recovery. We compared the spreadsheet provided by the SAO to the results of this algorithm run and found a match on two clients. Both had already been referred for overpayment recovery.

ADSA's contracts with providers require that the provider notify the department of a client death within 24 hours by phone, or seven days in writing. ADSA's case managers identify overpayments whenever it is clear that providers have been paid erroneously for services. But the recoupment of overpayments is not reconciled with SSPS payment records. Therefore, beginning with SSPS payment records could lead SAO to incorrectly determine that payments remain in error and corrective actions have not been taken.

We do question the method the SAO has used to project payments as a result of this finding. The auditor has reviewed a "selected valid sample." Whether or not the tests were random, the auditor used non-statistical sampling methods instead of project or extrapolates results. The AICPA's Audit Guide states, "Any sampling procedure that does not measure the risk is a non-statistical sampling procedure…" The auditor relies on judgment or intuition in interpreting the results of a sampling procedure, instead of available statistical theory. A New York State CPA Journal addresses non-statistical sampling at this site: http://www.nysscpa.org/cpajournal/2004/504/essentials/p30.htm. As stated in this opinion, "Such a view is potentially hazardous, because the auditor is permitted to ignore facts that are readily discernable to any practitioner, or legal adversary, who is knowledgeable in the application of statistical methodology."

- ***Ensure staff members understand the new state law (RCW9.35.020) effective July 1, 2004.***

Existing field procedures described above are sufficient to identify the rare instances in which someone is trying to receive a service intended for a deceased client.

Auditor's Concluding Remarks

To respond to each of the Department's points:

- We agree that assistance is not to be delayed pending issuance of a Social Security number. However, the agency, as required by 42 CFR 435.910 (e), must help the applicant complete an application to receive such a number. The Department did not provide us with evidence that it provided such help to its clients.

  The large number of potentially invalid Social Security numbers we found is an indication that the Department's tools are either not being used or are not working.

- The Code of Federal regulations requires clients to have valid Social Security numbers. No exception is made for widows using their dead husbands' numbers.

  When clients do not have valid Social Security numbers, the risk increases that providers could bill the Department on behalf of someone who is deceased. The Department must rely on a family member or the provider to inform it if a client dies, rather than being advised by the Social Security Administration. Again, the Department provided no evidence that it helped obtain numbers for widows without their own.

  The Department stated that beginning with SSPS payment records could lead us to incorrectly determining that erroneous payments have not been corrected. The Department provided no documentation to validate this statement.

  The Department also questioned our sampling techniques. We can reassure the Department that selecting a valid sample is a standard auditing procedure and that we made this selection randomly.

  The Department disagrees with our sampling methods because we projected to the population based on a non-statistical sample. However, this practice is accepted by audit standards. The American Institute of Certified Public Accountants' Codification of Statements on Auditing Standards, AU 350.03, states:

  > There are two general approaches to audit sampling: non-statistical and statistical. Both approaches require that the auditor use professional judgment in planning, performing, and evaluating a sample and in relating the evidential matter produced by the sample to other

> evidential matter when forming a conclusion about the related account balance or class of transactions. **The guidance in this section applies equally to nonstatistical and statistical sampling**. (Emphasis added.)

AU 350.04 continues:

> The third standard of field work states, "Sufficient competent evidential matter is to be obtained through inspection, observation, inquiries, and confirmations to afford a reasonable basis for an opinion regarding the financial statements under audit." Either approach to audit sampling, when properly applied, can provide sufficient evidential matter.

AU 350.26 states in part:

> The auditor should project the misstatement results of the sample to the items from which the sample was selected . . . .

The Department misquoted the AICPA Audit Guide by leaving out the word **sampling.** The AICPA's Audit Guide actually states,

> Any sampling procedure that does not measure the **sampling** [emphasis added] risk is a non-statistical sampling procedure.

Sampling risk differs from overall risk because it is just one piece of a much bigger picture. We agree that we did not measure sampling risk, as it is not a requirement for non-statistical sampling. In our determination of the sample size, however, we did evaluate other types of risk related to audit sampling.

We reaffirm our finding and recommendations.

Applicable Laws and Regulations

The Code of Federal Regulations is explicit regarding obtaining and verifying Social Security numbers as a condition of Medicaid eligibility. 42 CFR 435.910 (a) specifically states in part:

> The agency must require, as a condition of eligibility that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers (SSNs).

42 CFR 435.910 (g) states:

> The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the Commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

If a Medicaid applicant cannot remember or has not been issued a Social Security number, 42 CFR 435.910 (e) (1-3) states that the agency must:

(1) Assist the applicant in completing an application for an SSN;

(2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and

(3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

42 CFR 435.916 (a) states in part:

> The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months . . .

42 CFR 435.920 states:

> (a) In redetermining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.
>
> (b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of Sec. 435.910.
>
> (c) For any recipient whose SSN was established as part of the case record without evidence required under the SSA regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with Sec. 435.910.

The Medicaid State Plan incorporates the above references as applicable to Washington State's coverage and eligibility criteria when it states the following:

> The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

RCW 9.35.020 states in part:

> (3) No person may knowingly obtain, possess, use, or transfer a means of identification or financial information of another person, living or dead, with the intent to commit, or to aid or abet, any crime.
>
> (4) Violation of this section when the accused or an accomplice uses the victim's means of identification or financial information and obtains an aggregate total of credit, money, goods, services, or anything else of value in excess of one thousand five hundred dollars in value shall constitute identity theft in the first degree . . . .

04-04 The Department of Social and Health Services paid providers with Medicaid funds through the *Social Services Payment System* for services performed after the date of death.

Background

While most payments to providers from Medicaid funds are processed by the Medical Assistance Administration through the Medicaid Management Information System, some are made by other divisions or administrations of the Department of Social and Health Services through the Social Service Payment System (SSPS). Medicaid programs in these other sections of the Department include the Community Options Program Entry System, Supported Living Services, and Medicaid Personal Care.

During our 2003 audit, we reviewed Medicaid funds paid through SSPS and selected 29 individuals who appeared to have been provided services after their dates of death. We found that providers for eight of these clients received payments for services they reported to have provided after the individual's date of death.

Description of Condition

This year we again reviewed Medicaid amounts paid through SSPS for services provided after a client's death. As a result of our review of records for the period July 1, 2003 through December 31, 2003, we found 79 clients for whom these types of payments appeared to have been made. Of these, the Social Security Death Index indicated 71 were deceased; however, providers had received payment for services they reported they provided after their clients' dates of death. We analyzed these transactions further to determine which payments had been made with Medicaid funds. The table below summarizes the apparent inappropriate Medicaid payments made by the Department on behalf of services for deceased clients.

Administration/Division	Total Dollars	Total Medicaid Dollars
Division of Developmental Disabilities	$21,299	$15,534
Aging and Adult Services Administration	$58,812	$58,120
TOTAL	$80,111	$73,654

We shared our detailed results with the Department and requested any evidence it had that the payments to these providers were allowable. Two months later, the Department provided the name of one individual it agreed was deceased; however, it provided no additional evidence regarding the allowability of this payment or any of the other payments we had identified as being made on behalf of deceased clients.

Cause of Condition

The Department is largely dependent on the provider or family members to voluntarily report a client's death. Lack of timely notification or failure to notify leads to cases in which claims are paid after the recipient has died.

Effect of Condition

The Medicaid program is unnecessarily susceptible to loss or misappropriation because of the Department's inability to identify deceased clients in a timely manner. Providers can continue without detection to receive payment on behalf of deceased persons. The Medicaid amount of $73,654 apparently paid to providers inappropriately is included in the disclaimed amount in the first finding.

Recommendations

We recommend the Department:

- Establish procedures with the Department of Health and with providers that will provide notification of clients' deaths in a timely manner.

- Forward the instances of suspected provider fraud to its own Post-Payment Review Office or to the appropriate legal authorities.

Department's Response

The Department partially concurs with this finding and believes procedures have been implemented that target these concerns.

- ***Establish procedures with the Department of Health and with providers that will provide notification of clients' deaths in a timely manner.***

  Aging and Disability Services Administration (ADSA) has access to Department of Health on-line information on certificates of death. In addition, the Automated Client Eligibility System (ACES) nightly batch processes with the State Data Exchange, and the Beneficiary Data Exchange System returns Social Security Administration (SSA) notifications of death. The alert generated for field staff is described in the ACES User Manual at http://www1.dshs.wa.gov/esa/acesman/Sections/alerts/alert_253.htm.

  ADSA's field staff currently seeks reimbursement when it is clear that providers have been paid erroneously for services. Because there is no reconciliation process with Social Services Payment System (SSPS) payment files, it is not possible to determine whether a payment made in error has been recouped based on SSPS payment data. This is an area that needs further review.

  ADSA's current contracts with providers require that the provider notify the department of a client death within 24 hours by phone, or seven days in writing.

- ***Forward the instances of suspected provider fraud to its own Post-Payment Review Office or the appropriate legal authorities.***

  ADSA funds and actively participates in the Department's Payment Review Program (PRP) process and the development and implementation of algorithms designed to capture payments made for services after death. This algorithm is re-run quarterly and findings are referred to the Office of Financial Recovery or the Medicaid Fraud Control Unit for recovery.

Auditor's Concluding Remarks

We are familiar with the tools the Department uses to detect such payments. However, the potential exceptions we provided to the Department show that some unallowable payments may have been made. We asked the Department to analyze these potential exceptions. The Department stated it compared our data against its own records and found only two names that matched. The Department did not provide information substantiating that our other potentially unallowable payments were allowable; therefore, it is possible that we detected unallowable payments that the Department's procedures are not identifying. We reaffirm our finding and our recommendation that the Department investigate the allowability of the $80,111 we identified.

Applicable Laws and Regulations

The Office of Financial Management's *State Accounting and Administrative Manua*l, states in Section 85.32.10:

> . . . Agencies are responsible for processing payments to authorized vendors, contractors, and others providing goods and services to the agency. Agencies are to establish and implement procedures following generally accepted accounting principles. At a minimum, agencies are also to establish and implement the following:
>
> > 1. Controls to ensure that all expenditure/expenses and disbursements are for lawful and proper purposes . . . .

04-05 The Department of Social and Health Services, Medical Assistance Administration, did not provide the State Auditor's Office reliable, timely records for our audit of services provided to undocumented aliens.

Background

As a requirement for receiving federal Medicaid funds (CFDA 93.778), the Department of Social and Health Services must provide medical benefits to three groups: otherwise eligible residents of the United States who are citizens; aliens lawfully admitted for permanent residence; and certain aliens granted lawful temporary resident status. Undocumented aliens are not included in these three groups.

In most cases, if a state chooses to provide medical services to undocumented aliens, it must use its own funds. Federal Medicaid matching funds are available only if the medical services provided are the result of an emergency situation, including obstetrical services at the time of delivery. Emergency medical services are defined in the U.S. Code of Federal Regulations and the Medicaid State Plan. Non-emergency medical services provided to undocumented aliens cannot be charged to the federal government. The Department and the federal government define "emergency medical condition" as the sudden onset of a medical condition so severe that, without immediate medical attention, it would be expected that there would be serious jeopardy to a person's health; serious impairment of bodily functions; or a serious dysfunction of a bodily organ or part.

During our previous audit, Department records showed that 9,717 undocumented aliens received medical services from July 2002 through December 2002. Based on our risk analysis, we selected 169 of these patients in six service categories to determine whether all Medicaid-funded services provided were emergencies as defined by the law.

We found that non-emergency procedures, routine medical services, and durable medical equipment were provided to undocumented aliens and paid for with Medicaid funds. We found payments for adult day care, massages, dental fillings, routine eye exams, regular office visits and in-home care, as well as supervision of normal pregnancies and routine postpartum follow-up. Medicaid payments were made for eyeglasses and contact lenses, breast pumps, dentures, contraceptive devices, disposable incontinence garments, and replacement wheels for wheelchairs. We found payments for conditions such as menopause, cough, breast engorgement, and nearsightedness. As a result, we questioned $1,342,420 in state and federal costs.

Description of Condition

We reviewed this area again during our current audit, using data from the Department's Medicaid Management Information System. Department records showed that from July 2003 through December 2003, 12,119 undocumented aliens received medical services, an increase of 25 percent from the same six-month period in the previous year.

In an effort to test these services, we selected five categories that had been included in tests the previous year and that did not appear to conform to the federal government's definition of "emergency medical condition". These categories were: adult day care, nursing home care, in-home care, personal care and dental services. We found a total of 5763 clients in those categories. Using valid sampling techniques, we selected 347 clients for review. We attempted to evaluate internal controls and compliance with federal regulations with the limited information made available to us by Department staff. We encountered several difficulties with obtaining access to information for this audit, as follows:

- We were unable to independently interview line staff at the Medical Assistance Administration's Division of Medical Management, which is composed of physicians with the authority to approve medical procedures. All information given to us for this area was filtered through the Administration's Business and Finance Division. We were informed by staff in certain areas of the Administration that we had to be granted permission from management to speak with them. Despite our requests, we were never granted permission to speak with Division of Medical Management staff members and were unable to independently corroborate information about internal controls or about clients that the Division may have approved for emergency services. With the exception of the original data transactions, all other information for this area for the current audit was obtained only through management.

- We requested timely data about medical approvals from the Division of Medical Management's computer records. Although we easily obtained this information last year, this year we were instead provided five weeks later with a manually-prepared document that could not be relied on for audit purposes. Additionally, this document was provided to us by the Administration's Business and Finance Division rather than by its Division of Medical Management.

- The U.S. Social Security Administration would not permit us independent access to the State Online Query (SOLQ), which is a system that can verify Social Security numbers. This forced us to depend on the Department, which does have access, to perform all of our Social Security number verifications. As a result, the Department was aware of the transactions being tested. The Department then made alterations to the sample data in its computer systems that prevented us from completing our tests as planned. This action invalidated our sample and prevented us from reaching a conclusion. We were unable to determine if data originally given to us was faulty or if the current data was faulty.

In spite of these problems, we were able to obtain some information about the services we selected. We found:

- Non-emergency services apparently were provided to 274 undocumented aliens, or 79 percent of those tested. Although we were prevented by the Department's actions from completing our tests in this area, we estimate total costs in these cases were within a range of $3,951,473 - $5,141,726.

	Range	
Adult Day Care	$ 40,738	$ 40,738
Dental	1,385,417	1,495,629
Nursing Home	2,332,883	3,276,084
In-Home Services	125,622	252,617
Personal Care	66,813	76,658
	$ 3,951,473	$ 5,141,726

- The other 73 clients, or 21 percent of those tested, were improperly identified in the Department's System as undocumented aliens. We were able to verify from SOLQ that these clients had valid Social Security numbers, which undocumented aliens would not have. Therefore, the clients were not undocumented aliens whose services had to be restricted to emergencies. This is an example of the inaccuracies in the Department's client eligibility database. Because the Department routinely takes no action on Social Security Administration notifications of invalid numbers, we can place no reliance on any of the Social Security numbers in the Department's records.

While performing allowability work for another part of our audit of Medicaid, we found treatments and procedures provided to other undocumented alien clients that did not appear to be allowable under the Alien Emergency Medical Program. We found the following procedures provided to clients identified by the Department as undocumented aliens.

Routine infant and child health checks	$352,624.72
Supervision of normal pregnancy	$2,015,257.21
Routine postpartum follow-up	$208,007.93
Depressive disorder	$10,897.92
External hemorrhoids without complications	$1,229.46
Chronic renal (kidney) failure	$2,912,551.65
Breast pump kits	$48,406.76
Diapers/briefs	$3,352.91
Eye exams and treatments	$99,420.25
Farsightedness, nearsightedness, astigmatism, etc.	$26,265.73
Boys' dress eyeglasses frames	$4,140.60
Fitting and adjustment of glasses and contact lenses	$29,961.18
Hearing tests and comprehensive evaluations	$791.54
Massage	$405.39

Established patient-office or other outpatient visit	$214,918.05
Learning difficulties	$126.46
Menopausal or related issues	$159.25
Premenstrual tension syndromes	$87.50
Healthy Infant or child receiving care	$2,992.24
Calculation of radiation doses	$6,609.56
Influenza vaccine	$1,904.40
Therapeutic radiology	$9,938.13
Unwanted pregnancy	$546.11
Chemotherapy administration	$10,433.03

The above amounts were the result of 95,068 medical procedures, 15,494 of which were provided to clients identified by the Department as undocumented aliens, even though we found they possessed Social Security numbers. Because only citizens and legal aliens possess valid Social Security numbers and because of existing control weaknesses, we do not know how many of these procedures were performed on eligible persons. However, the remaining 79,574 procedures were provided to people identified by the Department as undocumented aliens with no social security numbers. The total costs for all of these services combined were $5,961,028.

Cause of Condition

The audit liaison system the Administration set up this year prevented us from obtaining the information and conducting the procedures necessary to complete our audit according to Generally Accepted Auditing Standards and in compliance with federal auditing regulations.

However, with regard to the results of the procedures we could complete, we believe the causes to be:

- Social Security numbers are not consistently verified prior to admitting clients into the Medicaid program. Further, the Department does not heed federal alerts notifying staff of invalid Social Security numbers

- The Department's accounting system does not differentiate undocumented aliens who have received emergency services from those who have received non-emergency services.

- When the Department enters an undocumented alien into its system in order to pay for emergency medical costs, it actually enters the client for a three-month period. During this time, it pays for all medical services provided to that client, whether emergency in nature or not. At the end of the three-month period, the client can be approved for an additional amount of time; this appears to occur continually, as we have seen clients in the system over the period of several years.

- Department regulations and instructions allow the provision of nursing facility care to undocumented aliens, without regard to the federal definition of emergency medical care.

Due to our lack of access to medical staff, we are unable to determine with reasonable assurance other causes for this condition. However, during our previous audit we found:

- Department staff stated the procedure manuals contain insufficient and unclear guidance and are often too technical for non-medical personnel to understand.

- In its eligibility manual, the Department lists certain medical diagnoses that are pre-authorized as emergencies. If a client who is an undocumented alien has a medical diagnosis that is not on the list, staff members are instructed to refer the case to the Department's medical staff. We found these referrals were not being made in a consistent manner.

- Medical consultants were slow to respond to staff questions about whether a condition is an emergency.

Effect of Condition

Because of an agency-imposed scope limitation, the State Auditor's Office did not have access to resources that would have allowed us to assess controls and to independently evaluate whether the Department was complying with Medicaid requirements in this area. Therefore, we cannot provide an opinion on compliance regarding allowable costs and eligibility of clients for Medicaid claims paid for undocumented aliens.

The cost of payments for such claims for the period of January 1, 2003 through December 31, 2003 was $90,590,041. Due to timing issues, we were unable to determine how much was paid in claims for the fiscal year period, July 1, 2003 through June 30, 2004; however, we believe the calendar year expenditures are an accurate approximation of the fiscal year expenditures. Half of this amount, or $45,295,021, was provided by federal Medicaid matching funds and the other half by state funds. The entire amount is included in the overall Program disclaimer.

Recommendations

With respect to compliance with audit requirements, we recommend the Department:

- Ensure that the State Auditor's Office has timely access to the information and resources it needs to complete its audit.
- Ensure managers understand the role of independent audits in reporting on the Department's compliance with applicable laws and regulations, when continued receipt of the funds depends on such compliance.
- Revise its regulations regarding care in nursing facilities to conform to federal regulations.

With respect to strengthening internal controls, we recommend the Department:

- Develop internal controls that require employees to verify applicants' Social Security numbers and heed alerts sent by the Social Security Administration pertaining to invalid numbers.
- Develop clear and complete policy and procedure manuals.
- Establish internal controls that ensure staff members make consistent referrals to medical consultants for diagnoses that are not listed in the eligibility manual and controls that ensure medical consultants respond promptly.
- Develop an accounting system that will differentiate emergency from non-emergency procedures so that the appropriate funds can be used to pay for the designated services.
- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this disclaimer.

Department's Response

The Department partially concurs with this finding.

This is a finding that was repeated from the SFY 2003 audit, and Medical Assistance Administration (MAA) has made important progress since then. MAA has instituted a transitional policy for this program and established workgroups to research and recommend a permanent policy. We shared the proposal with SAO since providing appropriate services to undocumented aliens is very complex because of the rules concerning the clients and the systems issues documented by the auditor. Once a permanent policy is approved, the MAA then can implement all necessary changes.

- *The procurement of the new Medicaid Management Information System (MMIS) will assist us in resolving issues cited by the auditors involving the receipt and verification of data. The new MMIS will allow DSHS to track Social Security Numbers faster and more accurately. It will*

lessen our reliance on manually produced data, and it will strengthen the tie between MMIS and the Automated Client Eligibility System (ACES).

- *Although SAO indicates that federal rules governing services for undocumented aliens are clear, the interpretation of these rules is complex. These system issues and the complexity involved in interpreting federal laws related to undocumented aliens were the primary source of the problems encountered by the auditors, not the liaison system established by the Department.*

- *As a result of last year's audit and similar complaints about data problems, the Department instituted an audit liaison system to provide a quality review of all data requests and prevent further problems in this year's audit. This did not limit SAO access to the information and data it needed, but established specific procedures that would have ensured accurate and timely responses to SAO inquiries. The liaison was in position to see that appropriate staffs were identified for additional contacts that SAO concerns were addressed promptly and effectively, and that data requests from SAO were clear and specific in order to speed their compilation and delivery.*

Auditor's Concluding Remarks

While some of the Department's data systems may need upgrading and interpretation of federal rules can sometimes be complex, neither of these circumstances apply in this case. The same systems and federal rules applied in previous years when we were able to complete our procedures. As described above, because we could not obtain information we needed through the Department's new audit liaison system, we were unable to complete our fiscal year 2004 audit according to professional auditing standards.

The Department's responses to our data requests were not produced in a timely manner. It took five weeks to obtain information that in the previous year took one week. The information we needed directly from the computer records of the Division of Medical Management was in the custody of the Division of Business and Finance for three weeks while the latter division manually prepared a spreadsheet of the information. Instead of providing us with the computer records we needed and requested, the audit liaison stated the Department chose this alternate format so our Office would not "misinterpret" the data. Because the format conversion presented an opportunity for the loss of data integrity, it significantly impaired the reliability of the data and prevented its use as audit evidence.

The response above implies that only the Department is capable of correct interpretation of the laws in this area. Federal regulations that govern the reimbursement of services for undocumented aliens are clear. The dual criteria of "sudden onset" and placing one's health in serious jeopardy or causing serious impairment or dysfunction to the body would not reasonably include routine services such as office visits and massages or equipment such as dress eye glass frames or breast pumps. Had we had access to the doctors in the Division of Medical Management, we might have received evidence that some of these services did constitute emergencies; absent that access, we assume they did not.

Applicable Laws and Regulations

Disclaimer

RCW 43.09.310 states in part:

> . . . The state auditor shall annually audit the statewide combined financial statements prepared by the office of financial management and make post-audits of state agencies. Post-audits of state agencies shall be made at such periodic intervals as is determined by the state auditor . . . .

American Institute of Certified Public Accountants, Statement of Position 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards,* Paragraphs 10.43 and 10.44 states, in part:

> The auditor is able to express on an unqualified opinion only if he or she has been able to apply all the procedures the auditor considers necessary in the circumstances. Restrictions on the scope of

> the audit – whether imposed by the client or by circumstances such as the timing of the auditor's work, an inability to obtain sufficient competent evidential matter, or an inadequacy of the accounting records – may require auditors to qualify their opinion or to disclaim an opinion.
>
> When restrictions that significantly limit the scope of the audit are imposed by the client, the auditor generally should disclaim an opinion on compliance.

The Office of Management and Budget's Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section .500(e) states:

> The auditor shall follow-up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with section .315(b) . . . .

Allowability and Eligibility

Section 1903 of the Act (41 U.S.C., Section 1396(b)) provides in part:

> (1) No payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or other wise permanently residing in the United States under color of law.
>
> (2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if-
>
> (A) such care and services are necessary for the treatment of an emergency medical condition of the alien,
>
> (B) such alien otherwise meets the eligibility requirement for medical assistance . . . and
>
> (C) such care and services are not related to an organ transplant procedure.

Washington Administrative Code 388-500-0005 describes emergency services as follows:

> Emergency medical condition means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
>
> Placing the patient's health in serious jeopardy;
> Serious impairment to bodily functions; or
> Serious dysfunction of any bodily organ or part.

It also defines emergency medical expense requirements as follows:

> A specified amount of expenses for ambulance, emergency room or hospital services, including physician services in hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

The Department's *A-Z Eligibility Manual* describes what constitutes an emergency medical condition. It states, in part:

> 1. . . . In order to be eligible for the Alien Emergency Medical (AEM) program, a person must: . . .
> a. Have an emergency medical condition. (Refer to the list of emergency medical conditions in the Medically Indigent section), ...

Washington Administrative Code 388-438-0110 describes alien emergency medical as follows:

> An alien, who is not eligible for other medical programs, is eligible for emergency medical care and services:
>
> (1) Regardless of their date of arrival in the United States;
>
> (2) Except for citizenship, meets Medicaid eligibility requirements as described in Washington Administrative Code 388-505-0210, 388-505-0220 or Washington Administrative Code 388-505-0110; and
>
> (3) Limited to the necessary treatment of an alien's emergency medical condition as defined in Washington Administrative Code 388-500-0005, except that organ transplants and related medical care services are not covered.

Washington Administrative Code 388-424-0010 describes alien status and eligibility requirements for medical benefits. Paragraph (3) states the extent of those services:

> An alien, who would qualify for Medicaid benefits but is ineligible solely because of his or her alien status, can receive medical coverage as follows:
>
> (a) State-funded categorically needy (CN) scope of care for …(i) Pregnant women, as specified in Washington Administrative Code 388-462-0015

Administrative Code 388-462-0015 states that care to pregnant women who do not meet eligibility requirements due to citizenship status will be provided under state funded programs only:

> A pregnant woman is eligible for CN scope of care under the state-funded pregnant woman program if she is not eligible for programs in subsection (2) of this section due to citizenship, immigrant or Social Security Number requirements.

Revised Code of Washington 43.20A.550 states that rules and regulations in conflict with federal law are deemed inoperative:

> . . . Any section or provision of law dealing with the department which may be susceptible to more than one construction shall be interpreted in favor of the construction most likely to comply with federal laws entitling this state to receive federal funds for the various programs of the department. If any law dealing with the department is ruled to be in conflict with federal requirements which are a prescribed condition of the allocation of federal funds to the state, or to any departments or agencies thereof, such conflicting part of chapter 18, Laws of 1970 ex.sess is declared to be inoperative solely to the extent of the conflict.

04-06 The Department of Social and Health Services, Medical Assistance Administration did not provide the State Auditor's Office with timely records and access to other sources of information needed to audit payments for certain types of procedures.

Background

While performing work in other areas of the Medicaid audit, we found charges for treatments and procedures that did not appear to comply with the State Medicaid Plan's descriptions of allowable types of service. Specifically, we found payments for treatments that appeared to be unallowable or that required pre-authorization. The Medical Assistance Administration's Division of Medical Management has medical consultants who may have authorized these procedures. We expanded our scope to determine the significance of the transactions and to determine if the procedures had received prior approvals from the Division.

Description of Condition

In the Department's records for the period January 1, 2003 through December 31, 2003, we found clients who appeared to have received elective surgical procedures for purposes other than remedying health conditions. Diagnostic and procedure codes on the providers' claims for reimbursement indicated these procedures included cosmetic and other elective surgeries that might not be allowable with Medicaid funds or that would require pre-authorization. The cost of the doubtful procedures we identified was $182,207. Because the related costs of these types of procedures for an individual client can occur over a period of more than one year, the total cost for them is unknown.

We performed our review with the information that was available to us. We encountered difficulties in obtaining information, as follows:

- We were not provided with access to line staff at the Division of Medical Management and were thus unable to obtain information from the consultants to help us determine what controls, if any, existed in this area or to help us determine if the procedures were truly unallowable.

- We did not receive documentation of requests for prior medical authorizations in a timely manner. During our previous audit, we had received these immediately after our request. This year, the Administration first stated it had no prior authorizations for the twelve specific clients whose medical approvals we had requested. Three weeks later, after our fieldwork ended, the Administration provided five of the authorizations they had earlier stated did not exist. This series of events, along with the problems described above, significantly impaired the reliability of the documents for audit evidence.

Cause of Condition

The liaison system the Administration set up this year prevented us from obtaining the information and conducting the procedures necessary to complete our audit according to Generally Accepted Auditing Standards and in compliance with federal auditing regulations.

Effect of Condition

Because of an agency-imposed scope limitation, the State Auditor's Office did not have access to resources that would have allowed us to assess controls and to independently evaluate whether the Department was complying with Medicaid requirements in this area. Therefore, we cannot provide an opinion on compliance regarding allowable costs and eligibility of clients for Medicaid claims paid for types of services that appear to be unallowable.

Recommendations

With respect to compliance with audit requirements, we recommend the Department:

- Ensure that the State Auditor's Office has timely access to the information and resources it needs to complete its audit.

- Ensure managers understand the role of independent audits in reporting on compliance with applicable laws and regulations when a provision of continued receipt of those funds is contingent on compliance.

- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this disclaimer.

Department's Response

The Department does not concur with this finding.

The SAO's identification of doubtful procedures or diagnoses that may not be allowable for payment with Medicaid funds was based on a vague request for information regarding prior authorization for 12 clients. It was sent to MAA for review without explanation or without being linked to a specific audit. Since the auditor did not review detailed records, agency staff randomly sampled 12% of the total questioned claims and found that all payments were supported by documentation as evidence of allowability, with the exception of one claim line amounting to $4.70. (Documentation of this review is available upon request).

The Department also disagrees with the auditor's assertion that DSHS ". . . did not provide SAO with timely records and access to line staffs . . .". On the contrary, the Department made every attempt to be responsive and timely despite the vague data request and generally poor communications. The Department created a liaison system to improve these communications, but the procedures were often ignored and circumvented by auditors.

This audit area is an excellent example of problems that could have been avoided with better communications and trust. It may assist both SAO and DSHS as they work to bridge these gaps during future audits.

Auditor's Concluding Remarks

The progress in this area was documented in the monthly updates that we prepared and gave to the Department from April 2004 until the last update on September 28, 2004. These and other communications kept the Department fully aware of the status of our audit.

We performed as detailed a review as we could with the information we were able to obtain. As pointed out in the finding, we were denied access to the Division of Medical Management, where we may have received additional information. The Department states in its response that it performed tests on some of our selected items and found only one it believed to be an exception. Since we were not able to complete our own tests and were never provided with the Department's results, we have no way to determine if we would have reached the same conclusion as the Department.

Applicable Laws and Regulations

RCW 43.09.310 states in part:

> . . . The state auditor shall annually audit the statewide combined financial statements prepared by the office of financial management and make post-audits of state agencies. Post-audits of state agencies shall be made at such periodic intervals as is determined by the state auditor . . . .

The American Institute of Certified Public Accountants, Statement of Position 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards*, Paragraph 10.43 and 10.44 states in part:

> The auditor is able to express on an unqualified opinion only if he or she has been able to apply all the procedures the auditor considers necessary in the circumstances. Restrictions on the scope of the audit - whether imposed by the client or by circumstances such as the timing of the auditor's work, an inability to obtain sufficient competent evidential matter, or an inadequacy of the accounting records - may require auditors to qualify their opinion or to disclaim an opinion.

> When restrictions that significantly limit the scope of the audit are imposed by the client, the auditor generally should disclaim an opinion on compliance.

Title 42 of the Code of Federal Regulations, Section 430.10 describes the authority of the state Medicaid plan.

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

The Department acknowledges the authority of the State Plan and states its commitment to abide by it in section 1.1 of the State Plan:

> As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Department of Social and Health Services submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

The State Plan, Attachment 3.1-B, Section 5.a. describes limitations on physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere. Subsection (1) includes as one of the limitations:

> Prior approval of non-emergent surgery and/or non-emergent hospital admission.

04-07 The Health Care Authority and the Department of Social and Health Services, Medical Assistance Administration, did not provide the State Auditor's Office with the records needed to audit the Basic Health Plus Program as part of Medicaid.

Background

Among Medicaid enrollees are children of parents and guardians who participate or have participated in the state's Basic Health Plan. The Basic Health Plan is designed to provide affordable health insurance to any eligible Washington resident and is administered by the Washington State Health Care Authority. An application for the Basic Health Plan by a parent may also be used as a joint application for Basic Health Plus Program for any child in the household. Children of Basic Health Plan members whose family income meets the net income standards for Basic Health Plus may be eligible for Medicaid benefits. The Health Care Authority provides the insurance coverage under Basic Health Plus, while the Medical Assistance Administration pays the premiums. Basic Health Plus spends approximately $71 million a year in Medicaid funds for more than 36,000 Washington children.

Federal auditing guidelines require that every year we review the issues that we reported in previous years to determine if they have been resolved. In our audits of state fiscal years 2001, 2002, and 2003, we reported findings related to weaknesses in the internal control structure in the Medical Assistance Administration's management of the Basic Health Plus Program.

- For 2001 we found multiple weaknesses in the internal controls over determining client eligibility.

- For 2002 we found that the Administration was in the process of restructuring controls and training staff. However, most of the corrective actions did not occur before fiscal year 2002 had ended and the internal control weaknesses that were found in 2001 continued in 2002.

- For 2003 we again reviewed the actions taken by the Administration to address these weaknesses and found it had made some significant improvements. However, most of the corrective actions did not occur before fiscal year 2003 ended. We also found weaknesses that the Administration had not yet addressed. These included:

    1. For self-employed households, income information was not confirmed with an independent source such as tax returns from the state's Department of Revenue or the Internal Revenue Service. The Department continued to accept self-declarations of income.

    2. The Administration could not provide evidence of procedures that ensured clients were reporting income changes immediately.

    3. Administration staff had not achieved its quotas for eligibility reviews.

    4. The Administration was not using the monthly reports from the Authority informing them of the subscribers being disenrolled due to noncompliance with the Authority's recertification process.

As part of our audit for two of the fiscal years, we also reviewed client compliance with income requirements.

- For 2001 we reviewed 60 client files and found 45 percent, or 27 clients, exceeded the net income standard for Medicaid eligibility and were not entitled to receive benefits.

- For 2003 we reviewed five wage-earning clients and five self-employed clients. We found that three of the wage-earning clients and all five of the self-employed clients were either currently ineligible for benefits or the Medical Assistance Administration could not provide the documentation to substantiate their initial eligibility.

Description of Condition

Our objectives this year were to document and test current internal controls and identify ineligible claims for services provided to Basic Health Plus children whose parents failed to meet the program's income standards. We informed the Medical Assistance Administration that we would perform tests similar to those in previous years and intended to select a valid sample and project our results.

In all of the previous years, the Health Care Authority promptly gave the State Auditor's Office the data required to audit the Basic Health Plus program. For the current audit period, we requested exactly the same data. This request was made on April 27. On May 24, the Authority provided some data which did not contain all of the information for which we had asked.

The Health Care Authority stated that, since our audit of Medicaid was not part of its own audit, it did not believe we had a right to obtain the additional data. The Authority also cited privacy issues and regulations under the federal Health Insurance Portability and Accountability Act (HIPAA) as another reason for withholding the data. However, HIPAA clearly gives the State Auditor's Office the authority to audit such information.

In a letter to the Health Care Authority signed by the State Auditor, our office cited our authority to obtain this data for testing purposes. The Authority's Assistant Attorney General agreed in a responding letter that the State Auditor's Office has access to data for audit purposes.

Following the exchange of letters, we made a second request for the data on June 23. On August 9, we received more data which not only was still incomplete but was also unclear. For instance, we could not always identify which data related to subscribers, which to spouses, and which to dependents. The data could not be used for our tests. Data which cannot be presented correctly and in a timely manner may be considered unreliable for audit purposes.

Cause of Condition

The audit liaison systems the Health Care Authority and the Medical Assistance Administration set up this year prevented us from obtaining the information and conducting the procedures necessary to complete our audit according to Generally Accepted Auditing Standards and in compliance with federal auditing regulations.

Despite our repeated requests for assistance in obtaining this data, we were never notified if the Administration used its rights under its new agreement with the Authority to ensure the Authority provided the data. This agreement, executed on April 2, 2004, was not disclosed to us, despite repeated requests, until September 17, 2004.

Effect of Condition

Due to an agency-imposed scope limitation, we are disclaiming an opinion on compliance related to allowable costs and eligibility of Medicaid clients under the Basic Health Plus program for the period July 1, 2003 through June 30, 2004. Claims paid on behalf of the beneficiaries of the Basic Health Plus program for the period January 1, 2003 through December 31, 2003 were $71,096,616. Due to timing issues, we were unable to determine the total claims paid for the fiscal year period, July 1, 2003 through June 30, 2004. However, we believe that the calendar year expenditures are an accurate approximation of the fiscal year expenditures. Approximately half of this amount, or $35,548,308, was paid with federal Medicaid funds and the other half with state Medicaid funds. The entire amount is included in the overall Program disclaimer.

Recommendations

With respect to compliance with audit requirements, we recommend the Medical Assistance Administration and the Health Care Authority:

- Ensure that the State Auditor's Office has timely access to the information and resources it needs to complete its audit.

- Ensure managers understand the role of independent audits in reporting on the Department's compliance with applicable laws and regulations, when continued receipt of the funds depends on such compliance.

We also recommend that the Administration work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this disclaimer.

Health Care Authority's Response

The Health Care Authority [HCA] disagrees with the part of the finding that claims HCA failed to provide requested data for Basic Health Plus members.

- *Prior to this year the State Auditor's Office has not requested from HCA, and has not been provided, data for Basic Health Plus Program members. The State Auditor's Office has requested, and been provided, data for the regular Basic Health Program members, as part of its audit of HCA's administration of the regular Basic Health Program. HCA does not handle eligibility determinations, or most other administrative aspects of the Basic Health Plus Program.*

- *The State Auditor's Office was not clear in April and May as to what data it wanted HCA to provide for the audit of the Basic Health Plus Program, most likely due to its failure to distinguish between the two different Basic Health programs.*
- *HCA requested the State Auditor's Office to provide a written request that specifically and clearly stated which data elements it wanted HCA to provide, and the statutory authority for HCA to provide the data. The State Auditor sent HCA a letter, dated June 23, 2004 that requested certain specific data elements for the Basic Health Plus and S-Medical programs. HCA promptly requested confirmation from its assistant attorney general that neither federal nor state health care privacy statutes prevented HCA from providing the requested data.*
- *On August 9, 2004, right after receiving guidance from our assistant attorney general, HCA sent the State Auditor's Office the full data files for the Basic Health Plus and S-Medical programs, precisely as requested in the June 23rd letter. We did not hear back from the State Auditor's Office regarding any concerns about the data files and believed we had satisfactorily responded to its data request.*
- *On November 2, 2004, HCA received a copy of the draft finding, which provided the first feedback from the State Auditor's Office to HCA that the data sent on August 9th had not met its needs. The draft finding stated the data provided by HCA on August 9th was incomplete and unclear.*
- *A meeting of the individuals involved with the data request, and HCA's response, was held on November 19, 2004. Prior to the meeting, an email was sent by HCA to the State Auditor's Office providing an explanation why some data elements requested by the auditor appeared not to be included. For instance, since the Basic Health Plus Program only covers children, it would be unlikely to have data files relating to a spouse or a dependent. At this meeting, the auditors admitted that although they had very specifically requested data files for the Basic Health Plus Program participants, in reality they had wanted HCA to provide data files for the regular Basic Health Program participants as well. At that meeting the auditors did not disagree that HCA had provided the specific data files that had been requested in the June 23rd letter, but indicated that HCA should have known that it also wanted data for regular Basic Health Program participants who had children in the Basic Health Plus program.*
- *The November 19th meeting concluded with both parties agreeing on the need for clearer future communications regarding data requests and data sharing, and HCA agreed to promptly request guidance from its assistant attorney general regarding whether there are any statutory limitations on HCA's ability to release information regarding regular Basic Health Program participants to the State Auditor's Office for future audits of DSHS or other state agencies. We have already submitted that request and expect to have a written response in January 2005.*
- *HCA is frankly mystified why the State Auditor's Office has included HCA in this finding, in light of the clear record that on August 9th HCA provided the data that was requested of it. In conversations following the meeting the only explanation we have been provided by the State Auditor's Office is that it is "too late" to amend the finding to reflect the conversations of the November 19th meeting.*

Auditor's Concluding Remarks

We have carefully reviewed the Health Care Authority's response and reaffirm our finding. At a meeting held with the acting director on November 19, 2004, we brought schedules showing the information received in the prior year that was requested and not provided during the current audit period. These schedules confirmed that the information we requested did exist. Therefore, we found there was no reason to amend the finding. We informed the acting director at this meeting that there would be a finding.

Department of Social and Health Services' Response

The Department partially concurs with this finding.

- *With respect to internal control weaknesses from 2001 through 2003, DSHS has implemented corrective action. DSHS staffs follow established procedures as set forth in the Department's EA-Z manual.*

- *We concur with the finding that administration staff had not achieved quotas for eligibility reviews. Audit plans were developed before staff knew that a reduction in staff would be implemented and that lead workers would have to carry a caseload as well as their other duties. We have now implemented procedures to ensure that the required number of reviews is completed.*

- *We disagree with the auditor's finding that the administration "is not using the monthly reports from the Health Care Authority (HCA) informing them that the subscriber is being disenrolled due to non-compliance with Authority's recertification process." The Basic Health subscriber is the parent in the Basic Health household, and their disenrollment does not affect the Basic Health Plus child's Medicaid eligibility. HCA does send the Department individual change notices that are acted upon in accordance with existing Medicaid policies. Changes that result in a child leaving the Medicaid caseload are acted upon immediately.*

- *We disagree with the auditor's findings related to income eligibility in 2001 and 2003. Use of only Department of Employment Security (ESD) quarterly income data does not provide the complete information for determining eligibility. The ESD information is not current and does not necessarily represent the household's actual earned income in the month of review. In addition, the household may have had allowable deductions that would be applied to the gross earned income, e.g., childcare and work expenses. The Department also disagrees with findings related to self-employed households and income changes. Department staff follows procedures for these areas as provided in the EA-Z manual.*

- *We disagree with the statement that "the Medical Assistance Administration did not use its rights under its new agreement with the Authority to ensure the Authority provided the data." The SAO did not request any information from DSHS, request DSHS assistance in securing information from the Health Care Authority (HCA) on its behalf or inform DSHS that it did not receive requested information from HCA. This is also evident in an e-mail from HCA's Administrator to SAO on November 16, 2004, expressing HCA's surprise at SAO's assertion that it did not receive requested information. It was not possible for DSHS to influence or impose any limitations on the auditors' ability to obtain data from HCA. However, DSHS has worked cooperatively with the federal Centers for Medicare and Medicaid Services (CMS), which verified it will not pursue any overpayment of Medicaid dollars as a result of this finding.*

Auditor's Concluding Remarks

Because we were unable to perform any testing of this area due to the lack of data, we do not know if the corrective actions the Department reported in its response have taken place. Our reply to the Department's responses that pertain to our 2001, 2002 and 2003 audits can be found in the State Accountability Reports for those years.

The Department's response above stated:

> *The SAO did not request any information from DSHS, request DSHS assistance in securing information from the Health Care Authority (HCA) on its behalf or inform DSHS that it did not receive requested information from HCA.*

However, on June 3, 2004, at our monthly update meeting with the Department's Office of Review and Consultation, which was our official liaison for the audit, we stated we were unable to obtain the required data from the Health Care Authority for our review of the Basic Health Plus Program. At that time we also informed the Department that our inability to test would require that we disclaim on the Basic Health Plus portion of the Medicaid audit and that this disclaimer would involve $71,096,615. We included this information in the document we presented at the time and requested that the Office distribute the document as needed. At every monthly meeting thereafter through the end of September, we reiterated this information both verbally and in writing. We also verbally requested the Department to help us obtain the data from the Authority.

Applicable Laws and Regulations

RCW 43.09.310 states in part:

> . . . The state auditor shall annually audit the statewide combined financial statements prepared by the office of financial management and make post-audits of state agencies. Post-audits of state agencies shall be made at such periodic intervals as is determined by the state auditor . . . .

The American Institute of Certified Public Accountants, Statement of Position 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards*, Paragraphs 10.43 and 10.44 states, in part:

> The auditor is able to express on an unqualified opinion only if he or she has been able to apply all the procedures the auditor considers necessary in the circumstances. Restrictions on the scope of the audit - whether imposed by the client or by circumstances such as the timing of the auditor's work, an inability to obtain sufficient competent evidential matter, or an inadequacy of the accounting records - may require auditors to qualify their opinion or to disclaim an opinion.
>
> When restrictions that significantly limit the scope of the audit are imposed by the client, the auditor generally should disclaim an opinion on compliance.

The Office of Management and Budget's Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section .500(e) states:

> The auditor shall follow-up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with section .315(b) . . . .

Section 6 of the interlocal agreement between the Health Care Authority and the Medical Assistance Administration states in part:

> a. During the term of this Interlocal Agreement and for one (1) year following termination or expiration of this Interlocal Agreement, the Contractor (Auditor's note: the Authority) shall give reasonable access to the Contractor, Contractor's place of business, client records, and Contractor records to DSHS and to any other employee or agent of the State of Washington or the United States of America in order to monitor, audit, and evaluate the contractor's performance and compliance with applicable laws, regulations, and this Interlocal Agreement.

Section 7 of the same agreement states in part:

> Material created by the Contractor and paid for by DSHS as a part of this Interlocal Agreement shall be owned by DSHS . . . .This material includes, but is not limited to: . . . computer programs; documents; . . . reports . . . .Material which the Contractor uses to perform this Interlocal Agreement but which is not created for or paid for by DSHS is owned by the Contractor; however, DSHS shall have a perpetual license to use this material for DSHS internal purposes . . . .

PL 104-191, Health Insurance Portability and Accountability Act of 1996, Section .1178 (a)(2)(c) states:

> STATE REGULATORY REPORTING – Nothing in this part shall limit the ability of a State to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.

Section .1171 (5) of the same statute states in part:

> Health Plan – The term 'health plan' means an individual or group plan that provides, or pays the cost of, medical care . . . Such term includes the following, and any combination thereof: . . .
>
> (E) The Medicaid program under title XIX . . . .

04-08 The Department of Social and Health Services, Medical Assistance Administration did not provide the State Auditor's Office with reliable, timely records for our audit of Proshare services.

Background

Since 1999, the Department of Social and Health Services has provided supplemental Medicaid funds to eligible public hospital districts with nursing home facilities that meet established criteria. These supplemental payments are intended to preserve access to health care in rural areas and are subject to the availability of federal matching funds. The Department's Medical Assistance Administration refers to these supplemental funds as Proshare and has provided for Proshare in an amendment to the Washington Medicaid State Plan.

Each state receiving these supplemental funds has the flexibility to determine the method used to calculate the payments. Federal regulations require that each state include in its state plan a detailed description of the specific payment method to be used; this method must be approved by the federal grantor. If this payment method is not included in a state's plan, the state must submit an amendment to describe the method; otherwise, the supplemental payments are not allowable.

Description of Condition

In order to identify expenditure trends, we included in our planning process a comparison of fiscal year 2004 expenditures to fiscal year 2003 expenditures. During that analysis, we identified a fiscal year 2003 discrepancy of $10 million between the state's official accounting system and the total of the Administration's own records. During our audit, we attempted to determine the cause of this discrepancy. In addition, as our audit proceeded, we found other significant issues, some resulting from previous Proshare payments that caused us to expand our scope. As a result, we also attempted to determine why:

- The Administration adjusted a fiscal year 2002 federal report to correct a $733 million dollar overpayment of state and federal funds it received in state fiscal year 2002.

- During the third quarter of fiscal year 2003, an additional adjustment of $16 million was required, after the initial adjustment, to resolve the fiscal year 2002 overpayment.

We were unable to perform the necessary review to determine if the payments the state made to the public hospital districts under the Proshare program were allowable and if the additional issues we noted could be reasonably explained.

The Administration stated that the Medicaid State Plan is the source of the payment method; however, we found no detailed description of the Administration's method in the State Plan, even though such a description is required by federal regulations.

The Administration also stated that the three discrepancies were due to errors in the calculation method. However, it did not respond to our questions regarding the number of years this incorrect method was used and did not provide us with a description of that method. The Administration also stated that the federal grantor approved its calculations used to adjust all three discrepancies. However, it provided no documentation to support this statement.

We were unable to independently interview line staff. All information given to us for this area was filtered through the Administration's Business and Finance Division. We were informed by staff in certain areas of the Administration that we had to be granted permission from management to speak with them. We made numerous requests for detail and supporting documentation which the Administration did not fulfill. Some replies to our requests were insufficient explanations consisting of only a word or two. In addition, the Administration regularly questioned our authority to expand our audit scope.

Cause of Condition

The Administration stated that the state and the federal grantor negotiated about payment methods and that an agreement was reached and executed by both parties. The Administration stated, however, that it did not feel it should allow the issue to be opened again for the State Auditor to review.

Effect of Condition

Because of an agency-imposed scope limitation, the State Auditor's Office did not have access to resources that would have allowed us to assess controls and to independently evaluate whether the Administration was complying with Medicaid requirements in this area. Therefore, we cannot provide an opinion on compliance regarding Proshare payments to public hospital districts with nursing home facilities.

Payments made to hospitals by this program during the time periods we attempted to audit were:

- State fiscal year 2002 - $995,021,957 (Federal portion: $497,510,979)
- State fiscal year 2003 - $122,238,168 (Federal portion: $ 61,119,084)
- State fiscal year 2004 - $ 76,412,880 (Federal portion: $ 38,206,440)

The federal portion is an approximation; state funds provided the costs not covered by federal funds. The total 2004 amount is included in the overall Program disclaimer.

Recommendations

With respect to compliance with audit requirements, we recommend the Department:

- Ensure that the State Auditor's Office has timely access to the information and resources it needs to complete its audit.

- Ensure managers understand the role of independent audits in reporting on compliance with applicable laws and regulations when a provision of continued receipt of those funds is contingent on compliance.

- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this disclaimer.

With respect to compliance with federal regulations, we recommend the Department amend the Medicaid State Plan to include a detailed description of its specific Proshare payment method and obtain federal approval for this amendment.

Department's Response

The Department does not concur with this finding:

- *As noted earlier, the Department did not limit SAO access but requested the auditors work with the specific DSHS liaison identified for this audit area. The Division of Business and Finance is responsible for the administration of the ProShare program, which is complex. Accuracy requires intensive management review of pertinent calculations and information presentations. The Department informed SAO that it would be especially necessary to follow the liaison procedures in order to achieve accurate and timely responses.*

- *The auditor also asked MAA to produce "documentation that confirms that the fed required the recalculation that resulted in an apparent $10 million discrepancy that we found, as well as CMS approval of the payment of or payment calculation/methodology that was used…" MAA's repeated response was that the Department does not have written documentation that confirms the federally required recalculation, but it did provide SAO with the CMS approval of our methodology.*

- *While we appreciate SAO's concern over the lack of detailed information about ProShare recalculation, the Department did provide all requested information. It is important to note that the ProShare program is being phased out pursuant to an agreement between Washington State and the federal Department of Health and Human Services (HHS). This agreement was not written into the Medicaid State Plan, but it was confirmed by HHS staff during the audit.*

- *HHS has closely reviewed the ProShare calculations during the phase-out period (which is from 2002 through 2005). Because of that, DSHS does not believe this finding will result in a federal disallowance. The payments have also been reported on the federal report (CMS-64), and CMS is fully aware of these payments on a quarterly basis.*

Auditor's Concluding Remarks

We reaffirm that the Department's actions prevented us from achieving the goal of *Government Auditing Standards*, *Field* Work Standards, 4.03 (c) which states:

> Sufficient competent evidential matter is to be obtained through inspection, observation, inquiries, and confirmations to afford a reasonable basis for an opinion regarding the financial statements under audit.

The audit liaison system in place did not allow us to meet this standard. Additionally, the audit liaison system attempted to force us to rely on the Department's representations as to the existence or accuracy of evidence. In effect, the Department was attempting to perform the work of the auditor, instead of allowing the auditors to perform an independent audit and to reach a valid conclusion.

Our discussion with the federal Department of Health and Human Services Office of Inspector General on September 9, 2004 with respect to this issue, indicated that if the methodology for Medicaid supplemental payments is not in the State Plan it is an unallowable cost. Therefore, it became a reportable issue.

The Department did not have adequate documentation to support over $1.2 billion in expenditures made over the past three years. We reaffirm our finding.

Applicable Laws and Regulations

Disclaimer

RCW 43.09.310 states in part:

> . . . The state auditor shall annually audit the statewide combined financial statements prepared by the office of financial management and make post-audits of state agencies. Post-audits of state agencies shall be made at such periodic intervals as is determined by the state auditor . . . .

The American Institute of Certified Public Accountants, Statement of Position 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards*, Paragraph 10.43 and 10.44 states, in part:

> The auditor is able to express on an unqualified opinion only if he or she has been able to apply all the procedures the auditor considers necessary in the circumstances. Restrictions on the scope of the audit - whether imposed by the client or by circumstances such as the timing of the auditor's work, an inability to obtain sufficient competent evidential matter, or an inadequacy of the accounting records - may require auditors to qualify their opinion or to disclaim an opinion.
>
> When restrictions that significantly limit the scope of the audit are imposed by the client, the auditor generally should disclaim an opinion on compliance.

Compliance

The federal State Medicaid Manual, subpart 6002.4, mandates that states include a detailed description of their specific payment methodology in their state plans. If this methodology is not currently included in their plans, they must submit an amendment to include it.

The same manual, subpart 6005.1, Other Policy Clarifications, states in part:

> The responsibility of complying with the Medicaid . . . requirements as explained herein, and documenting such compliance, rests with you . . . . (our) oversight of your compliance is performed generally after the fact through an assessment, plan validation, or other audit type activity . . . .

04-09 The Department of Social and Health Services, Aging and Disability Services Administration, did not provide the State Auditor's Office with timely records we needed to determine if Medicaid payments are made only to nursing homes meeting federal health and safety standards.

Background

Under the Medicaid program, states may receive federal financial assistance for patients receiving services in nursing homes. To qualify for federal participation, nursing homes must meet certain health and safety standards.

Although the Department's Medical Assistance Administration has primary responsibility for ensuring that ineligible providers are not reimbursed, the Department's Aging and Disability Services Administration has primary responsibility for conducting health and safety inspections at nursing homes. If Aging and Disability Services finds that a nursing home is not meeting federal standards, it notifies the U.S. Department of Health and Human Services, which then sends a denial of payment notice to the facility and to the Aging and Disability Services and Medical Assistance Administrations. This notice prohibits the payment of federal funds for any new Medicaid admissions to the facility until the condition is corrected.

During our 2002 audit, we found that neither Aging and Disability Services nor Medical Assistance had a complete record of nursing homes placed in denial-of-payment status. We compared both Administrations' records with the list maintained by the federal government and found Aging and Disability Services to have a 14 percent discrepancy rate and Medical Assistance to have a 33 percent discrepancy rate. During that audit, the Department concurred with our results and instituted a corrective action plan in which Medical Assistance would track the denial-of-payment notices directly with the federal government, rather than relying on Aging and Disability Services, as it was then doing.

During our 2003 audit, we sought to determine whether this internal control improved the accuracy of the Department's records. We compared the federal government's denial-of-payment list with the records of Medical Assistance and Aging and Disability Services for 36 nursing homes. We found that Medical Assistance records did not include 19 of the 36 nursing homes, or 53 percent of those that were on the federal government's list. Additionally, we found Medical Assistance did not monitor to ensure that payments for new Medicaid admissions were not paid to nursing homes in denial-of-payment status.

Description and Cause of Condition

We attempted to follow-up on this issue as federal regulations require. However, we encountered difficulties in obtaining access to information for this audit.

- We requested the Aging and Disabilities Services Administration's Denial of Payment Log to complete our review. That Administration reported it could not produce the two-page report it had provided in the past and suggested a 58-page document as a substitute. We agreed to the substitute but never received it. This prevented us from comparing the log to the records of Medical Assistance to determine if all Aging and Disability Services survey decisions regarding lack of compliance with health and safety standards had reached Medical Assistance. After the end of our fieldwork, Aging and Disability Services provided the two-page document we had originally requested**.**

- We were not permitted to have free access to the Medical Assistance Administration's line staff to complete our assessment of internal controls in that area. The liaison system Medical Assistance set up this year prevented us from obtaining the information and conducting the procedures necessary to complete our audit according to Generally Accepted Auditing Standards and in compliance with federal auditing regulations.

Effect of Condition

We were unable to determine if there was a discrepancy rate for the current audit period. Because of the agency-imposed scope limitation, the State Auditor's Office did not have access to resources that would have allowed us to assess controls and to independently evaluate whether the Department was complying with Medicaid requirements in this area. Therefore, we cannot provide an opinion on compliance related to allowable costs and eligibility of nursing homes for Medicaid payments.

Payments made to nursing homes for Medicaid clients during the period January 1, 2003 through December 31, 2003 were $514,305,248. Half of these costs, or $257,152,624, was paid with federal funds, and the other half with state funds. Due to timing issues we were unable to determine the claims paid for the fiscal year period, July 1, 2003 through June 30, 2004. However, we believe that the calendar year expenditures are an accurate approximation of the fiscal year expenditures. The entire amount is included in the overall Program disclaimer.

Recommendations

We recommend that the Department:

- Ensure that the State Auditor's Office has timely access to the information and resources it needs to complete its audit.
- Ensure managers understand the role of independent audits in reporting on compliance with applicable laws and regulations when a provision of continued receipt of those funds is contingent on compliance.
- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this disclaimer.

Department's Response

The Department does not concur with this finding.

The Description and Cause of Condition section of the SAO report states that not having the Aging and Disability Services (ADSA) log "prevented us from comparing the log to the records of Medical Assistance Administration (MAA) to determine if all Aging and Disability Services decisions regarding lack of compliance with health and safety standards had reached Medical Assistance." All decisions of ADSA related to compliance with health and safety standards do not need to reach MAA. The only decisions that need to reach MAA are those that result in a Denial of Payment for New Admissions. Those are sent directly to MAA by the Centers for Medicare and Medicaid Services (CMS).

Denial of Payment for New Admissions is an enforcement remedy when certain conditions are not met. A mandatory statutory component must be imposed when a facility is out of compliance for 90 days in a row. At other times, it is discretionary. When a nursing facility is dually certified for Medicare and Medicaid, or is only Medicare-certified, CMS has primary jurisdiction to impose the Denial of Payment for New Admissions remedy. All nursing homes in Washington that choose to have Medicaid are required by state statute to also be certified for Medicare. Thus, the Residential Care Services division of ADSA only recommends an enforcement remedy under federal law. CMS imposes the enforcement remedy and Medical Assistance implements it with the Medicaid Denial of Payment for New Admissions. The Residential Care Services log identifies what was recommended. CMS has a log which identifies what it imposed. This is the log that should be matched up with Medical Assistance implementation of not paying for new admissions during the time frame of the enforcement remedy. CMS may not always impose a remedy when it is discretionary, and many facilities come into compliance during the notice period of the remedy. When that happens, they are not subject to the Denial of Payment for New Admissions.

CMS has sent the Department a letter of approval for the method of communication that has been adopted regarding the Denial of Payment for New Admissions. Copies of all letters that CMS sends to facilities regarding this remedy are sent directly to MAA.

Residential Care Services will work to provide training to key staff so that the State Auditor's Office has timely access to the information and resources it needs to complete its audit. It will also ensure its staffs understand the role of independent audits.

The Department also does not concur with SAO's statement under the "Description and Cause of Condition" relating to this finding.

MAA staffs and management met with the field auditor on August 16, 2004, per SAO's request for an entrance interview. We did not receive additional questions or information after this meeting. In fact, at this meeting the field auditor was given a specific staff person for future contact, if needed. As noted elsewhere, one result of last year's audit complaints about data problems was that the Department instituted an audit liaison system that included quality review of all data requests. The Department did not limit SAO's access to data but did request that it work with the audit liaison in order to ensure accurate and timely responses and to make sure the Department could respond quickly to SAO concerns.

Auditor's Concluding Remarks

In last year's audit, we found the corrective action plan instituted by the Department as a result of previous audits was not working as management intended. Rather than improving the condition, we found a deterioration of internal controls and an accompanying increase in the risk that nursing homes may be paid with federal funds when they are not in substantial compliance with health and safety standards.

We are required by federal auditing standards to review areas in which weaknesses are found until the situation is resolved or for three years or until the federal government indicates it is satisfied with whatever corrective action has been taken. Since none of these conditions applied for the fiscal year 2004 audit, we attempted to follow up on the issue as required.

It is inappropriate for the Department to withhold information because it believes it is not relevant or significant. The auditor should be given the information requested and have an opportunity to examine it and discuss it with the Department before the auditor decides its importance.

When the Department gave us the response to this finding, we were given, for the first time, a letter dated October 14, 2004 written by the federal Centers for Medicare and Medicaid Services to the Aging and Disability Services Administration. This letter stated the Aging and disability Services did not have to notify the Medical Assistance Administration of providers in denial of payment. In this letter, the federal government assumes the full responsibility for this communication to the state. The formal arrangement between the Centers and the Administration appears to have occurred six weeks after our field work ended and well into fiscal year 2005, which is outside the scope of our audit...

Although we did not receive the log of the Aging and Disability Services Administration in time for us to compare it with logs from the other two sources, we did receive the Medical Assistance Administration's log and the Centers' log. We compared those two and found some discrepancies. Out of the 12 providers we reviewed, we found two providers that the Centers reported to be in denial-of-payment for which the Department did not have an accurate record, and we found a provider that the Department reported to be in denial-of-payment for which the Centers did not have a record. The discrepancies may indicate that communications between the Centers and the Medical Assistance Administration could be improved.

Applicable Laws and Regulations

Disclaimer

RCW 43.09.310 states in part:

> . . . The state auditor shall annually audit the statewide combined financial statements prepared by the office of financial management and make post-audits of state agencies. Post-audits of state agencies shall be made at such periodic intervals as is determined by the state auditor . . . .

The American Institute of Certified Public Accountants, Statement of Position 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards*, Paragraph 10.43 and 10.44 states in part:

> The auditor is able to express on an unqualified opinion only if he or she has been able to apply all the procedures the auditor considers necessary in the circumstances. Restrictions on the scope of the audit - whether imposed by the client or by circumstances such as the timing of the auditor's work, an inability to obtain sufficient competent evidential matter, or an inadequacy of the accounting records - may require auditors to qualify their opinion or to disclaim an opinion.
>
> When restrictions that significantly limit the scope of the audit are imposed by the client, the auditor generally should disclaim an opinion on compliance.

The Office of Management and Budget's Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section .500(e) states:

> The auditor shall follow-up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with section .315(b) . . . .

Compliance

Title 42 of the Code of Federal Regulations, Section 442.12 (a) states:

> The Medicaid agency may not execute a provider agreement or make Medicaid payments to a facility unless the Secretary or the State survey agency has certified the facility.

42 CFR 483.1 describes all of the conditions which must be met before certification can take place.

42 CFR 488.454 (b) states:

> In the cases of State monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until
>
> (1) CMS or the State determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or
>
> (2) CMS or the State terminates the provider agreement.

04-10 The Department of Social and Health Services, Division of Developmental Disabilities, does not have adequate internal controls over its pharmacy drug inventory purchased with Medicaid funds.

Background

Medicaid-funded intensive services are provided in five state operated residential habilitation centers for individuals with developmental disabilities needing a high level of nursing care or skill development. Four of the five centers (Yakima Valley School, Lakeland Village, Fircrest, and Rainier School) have on-site pharmacies. The number of residents living in the four centers ranges from approximately 110 to 370.

Three types of medications are available at the center pharmacies:

- Over-the-counter medicine can be obtained without a prescription. Examples are aspirin and antacids.
- Non-scheduled prescription drugs must be ordered by a doctor or other health care professional with authority to prescribe medications. Examples are antibiotics and blood pressure medications.
- Scheduled drugs, also known as controlled substances, must be dispensed only by prescription and are heavily controlled by federal and state laws and Board of Pharmacy rules. For instance, these drugs must be securely locked, logged in detail by location and usage, and continuously inventoried. Examples are brand-names such as Vicodin and Percocet.

Description of Condition

We reviewed the inventory controls, ordering and receiving procedures, and access to medications held for destruction. We found the following weaknesses in internal controls:

	Lack of inventory controls	Ordering and receiving functions not separated	Unrestricted access to drugs held for destruction
Yakima Valley School	X		X
Lakeland Village	X		X
Fircrest	X	X	X
Rainier School	X	X	

None of the pharmacies we reviewed had an inventory system capable of tracking or monitoring the quantity of medications consumed. In an effort to determine the accuracy of the pharmaceutical inventory, we selected oral medications at each pharmacy, calculated the ending inventory for the year, and compared that calculation to the actual ending inventory recorded by the pharmacy. We also calculated the estimated value of the pills for which the pharmacies could not account and found the following:

	Types of Medications Reviewed	Estimated Unaccounted for Pills	Estimated Associated Dollar Amount for Unaccounted for Pills
Yakima Valley	208	527,737	$187,178
Lakeland Village	181	311,510	$86,094
Fircrest	199	323,855	$160,774
Rainier	352	241,843	$95,287
Totals		**1,404,945**	**$529,333**

Specific Tests of Scheduled Drugs:

Because of the close controls exerted over scheduled drugs by federal and state officials, we found fewer internal control weaknesses related to these drugs. However, at two pharmacies, we did find the following weaknesses related to monitoring and safekeeping of scheduled drugs:

Fircrest

- The safe containing some scheduled drugs was not locked.
- From the infirmary's scheduled drug log, we selected 11 entries that noted drugs had been returned to the pharmacy. We attempted to trace each of these items to the pharmacy's return log and identified issues with the returns in eight instances:
  - We found four instances in which required signatures were missing in the transfer between the infirmary and the pharmacy. In these cases, a total of 20 pills from controlled substances such as Ativan, Vicodin and Percocet were unaccounted for in the pharmacy.
  - We found four other instances in which pharmacy procedures were not followed but no drugs were missing.

Rainier School

- Only one person performs the inventory count of Schedule II controlled substances, and the name of the counter is not recorded and retained.
- During the time of our review, one of the drawers containing scheduled drugs was not locked.

Cause of Condition

With staff shortages, the pharmacy employees did not consider control of non-scheduled drugs to be a high priority because the cost of a single item is normally not high. The Division did not explain what caused the loss of the scheduled drugs.

In addition, the centers do not always realize that drugs are part of the Department's consumable inventories and should be subject to at least the same inventory controls as food, clothing, etc. The Office of Financial Management has not made it clear in its inventory requirements that drug supplies are particularly high-risk items requiring firm controls.

Effect of Condition

Weak drug inventory practices increase the risk of loss or misappropriation. Losses may not be detected in a timely manner, if at all. We estimate the centers had a loss of at least $529,333 in drugs. This amount is included in the amount in the overall Program disclaimer. In addition, the Fircrest pharmacy cannot account for 20 pills from its controlled substances supply.

Recommendations

We recommend:

- All pharmacies develop and follow inventory practices for non-scheduled prescriptions and over-the-counter medications and for controlled substances that are dispersed around the pharmacy.
- Rainier School and Fircrest segregate the responsibilities for ordering and receiving drug inventory.
- Yakima School, Lakeland Village and Fircrest restrict access to drugs being held for destruction.

- Fircrest establish tighter controls over receipt of controlled substances returned from the infirmary to the pharmacy.

Department's Response

The Department concurs with this finding.

- ***All pharmacies develop and follow inventory practices for non-scheduled prescriptions and over–the–counter medications and for controlled substances that are dispersed around the pharmacy.*** *A Process Improvement Team has been chartered by Linda Rolfe, Division Director. The purpose of the team is to design inventory practices that ensure control of scheduled and non-scheduled prescriptions and over-the-counter drugs. Current inventory controls will be reviewed and improved. The team will define mechanisms for tracking and monitoring the quantity of medications consumed. The team is comprised of pharmacists and lead people from each of the residential habilitation centers and will be led by the division's Performance and Quality Improvement program manager. Recommendations with implementation strategies will be made no later than April 30, 2005.*

- ***Rainier School and Fircrest School segregate the responsibilities for ordering and receiving drug inventory.*** *Drug ordering and receiving will be segregated. A printout confirmation of all drugs ordered will be signed by the person ordering the drugs. The person receiving the drugs will compare the received drug confirmation and drug packing slips and sign these. The person ordering drugs will no longer be the person who receives them. The signed forms will be filed as a permanent record of all transactions.*

- ***Yakima School, Lakeland Village, and Fircrest restrict access to drugs being held for destruction.*** *Each pharmacy will establish a site within the pharmacy that can be secured where all outdated drugs awaiting disposal will be stored no later than January 1, 2005.*

- ***Fircrest establish tighter controls over receipt of controlled substances returned from the infirmary to the pharmacy.*** *A new system to monitor controlled substance use is in place at the Fircrest Infirmary. Fircrest Pharmacy has obtained "Controlled Substance Record" books from Western State Hospital (state form #(WSH 14-02A (04-95))) that will serve as a single record for any pharmacy delivery/return of all Schedule II-V drugs at the infirmary. This same book will be used to track individual doses administered to clients admitted to the Fircrest Infirmary.*

Auditor's Concluding Remarks

We appreciate the Department's plan to address this finding and look forward to its actions to resolve these control weaknesses. We will review the Department's progress during our fiscal year 2005 audit.

Applicable Laws and Regulations

Code of Federal Regulations, Title 21, Section 1301.75, paragraph b states:

> Controlled substances listed in Schedules II, III, IV, and V shall be stored in a securely locked, substantially constructed cabinet. However, pharmacies and institutional practitioners may disperse such substances throughout the stock of noncontrolled substances in such a manner as to obstruct the theft or diversion of the controlled substances.

Washington Administrative Code 246-865-060 (6)(d) states in part:

> At least once each 24 hours, the amount of all Schedule II controlled substances stored in the facility shall be counted by at least two persons who are legally authorized to administer drugs.

The Office of Financial Managements *State Accounting and Administrative Manual*, Section 35.10 contains detailed requirements for inventory systems for consumable inventories; however, it does not mention drug inventories.

04-11 The Department of Social and Health Services, Medical Assistance Administration, is not complying with federal regulations that require people receiving Medicaid payments to have valid Social Security numbers.

Background

The Department of Social and Health Services must require, as a condition of eligibility, that each individual, including children, applying for Medicaid services furnish his or her Social Security number. Federal regulations also require the Department to verify the number given with the Social Security Administration to ensure it was actually issued to the individual who supplied it and whether any other number has been issued for that individual. If an applicant does not remember or has not been issued a number, the Department must assist the individual in applying for one. Under these circumstances, the Department must obtain evidence to establish the age, citizenship or alien status, and true identity of the applicant.

When the Department approves an applicant for Medicaid, it enters the client information into the Department's Automated Client Eligibility System (ACES). This information in ACES is then transferred electronically into the Medical Management Information System (MMIS), which the Department's Medical Assistance Administration uses to process claims and initiate payments. The Administration stated that all Medicaid clients, except those admitted through the Involuntary Treatment Act, should be and are entered into ACES upon enrollment.

Description of Condition

During our audit of other areas of Medicaid, we found numerous instances in which no Social Security numbers were listed in the MMIS records for Medicaid clients. We also found instances in which two or more people shared the same number and other cases in which MMIS made payments for medical services for clients who were not listed in ACES.

Because of the apparent pervasiveness of these conditions, we expanded the scope of our audit. We reviewed all clients in the MMIS database for the period January 1, 2003 through February 16, 2004 who had payments made for them but who did not have a Social Security number in MMIS. We eliminated several groups in an effort to limit our work to the clients for whom Medicaid payments were made and a social security number should have been obtained. The groups that we eliminated were as follows:

- Clients in the Alien Emergency Medical Program. These individuals would not have Social Security numbers because they are undocumented aliens. Additionally, we reviewed these payments in other parts of our audit.

- Clients whom we knew from other audit steps had procedures paid only with state funds.

- All children with a birth date in 2003. Although parents must obtain Social Security numbers for their children, we considered that this task would not be uppermost to parents confronted with very ill infants. We believed the exception rate would be unusually high for this group and might distort results. After one year of age, however, most parents are likely to have obtained Social Security numbers for their children for tax purposes, and the Department would have had sufficient time to obtain those numbers.

  After removing these groups, we found 44,597 clients who had no Social Security numbers associated with MMIS payments for medical services provided to them. These payments totaled $68,022,531. To determine if Social Security numbers for these clients at least existed in ACES, where Medicaid clients should be and are almost always enrolled, we selected a valid sample for review. This sample consisted of 322 clients, for whom we found 112 exceptions, or 35 percent of those reviewed. These exceptions fell into three areas, all of which could be susceptible to fraud.

- For 15 percent, we found no record of a Social Security number in either ACES or MMIS. Actual and projected costs for this group were at least $8,599,041.

- For 13 percent, ACES noted the Social Security number was invalid, but the clients were enrolled in Medicaid anyway. Actual and projected costs for this group were at least $9,181,909.

- For 7 percent, we found no ACES record indicating these clients had ever been enrolled in Medicaid. The Administration previously had indicated it did not believe this situation could occur, yet actual and projected payments to providers for this group were at least $4,223,128.

Cause of Condition

- The Department enrolls into the Medicaid program a significant number of clients who do not provide valid Social Security numbers. It has no consistent procedures to assist clients in obtaining Social Security numbers if needed. Additionally, the Department is not verifying the age, citizenship or alien status, and/or true identity of the applicant before enrollment. In other parts of our audit, we found the Department does not use its access to Social Security's State On-Line Query system to verify the validity of Social Security numbers presented by clients.

- Computer interface problems occur between ACES and MMIS.

- Clients can be entered into the Medicaid program and MMIS without going through the standard application process that enters them into ACES and verifies eligibility.

Effect of Condition

Each claim paid on behalf of a client who has no Social Security number, who has made no application for one, or who possesses an invalid one is an unallowable cost. Approximately half of the actual and projected costs of $22,004,078, or $11,002,039, was paid with federal funds and the other half with state funds. The total amount is included in the overall Program disclaimer.

Recommendations

We recommend the Department:

- Establish procedures to require staff members to obtain client Social Security numbers or assist those without a number to obtain one upon application.

- Establish procedures to require staff members to obtain evidence establishing the true identity of an applicant.

- Verify Social Security numbers for all Medicaid clients using the State On-line Query.

- Require staff members to heed Social Security number alerts sent by the Social Security Administration and take action to resolve them.

- Resolve the computer interface problems between ACES and MMIS.

- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to Medicaid must be reimbursed by the state.

Department's Response

The department partially concurs with this finding.

A similar finding was part of the SFY 2003 audit (No. 03-04), and we have taken steps to address the issues cited. Specifically, the Department convened a Cross-Agency Workgroup to review options to enhance established procedures related to verification of Social Security Numbers (SSN) in the Automated Client Eligibility System (ACES), and we have taken necessary steps to address SSN verification procedures, staff notification/alerts, etc. Newly established automated verification of SSN for each ACES entry is scheduled to be implemented in February 2005.

Since ACES is the System of Record for Medicaid eligibility, the validation of SSN occurs in that system. The Department complies with federal requirements and the State Plan and is addressing previously identified deficiencies. Although the Medicaid Management Information System (MMIS) is required to include the SSN as a data element (per State Medicaid Manual Chapter 11), payment is based on client identifier, which relies on eligibility information collected and passed to MMIS from ACES.

The Department recognizes that ACES/MMIS interface problems exist. We will continue to assess, prioritize, and resolve interface issues as they are identified. The procurement of a new MMIS includes a complete assessment of the ACES/MMIS interface. The workgroup has been established to review and assess interface issues, provide recommendations, and work with the vendor of the new MMIS to develop a new ACES/MMIS interface. One specific problem related to the interface of SSN has been identified by the Department. In instances where a Medicaid-eligible client has multiple ACES entries, where <u>one</u> of those entries does not contain a SSN and one entry does, the SSN is not passed to MMIS. A number of the clients included in the sample SAO data sent to the Department fell into this category, and the Department is addressing this issue.

WAC 388-476-0005 outlines SSN requirements for cash, medical or food assistance benefits. It should be noted that, in addition to the Alien Emergency Medical program, there are exceptions to the SSN requirement, including refugee assistance and detoxification services. It should also be noted that there are client eligibility categories such as Foster Care/Adoption Support services where the foster child's SSN is not carried in either ACES or the MMIS for confidentiality reasons. All of the above categories were represented in the sample SAO data reviewed by the Department.
There are several valid conditions in which Medicaid clients' information is entered directly into the MMIS without going through ACES. In those cases, SSNs may not be obtained at the time of eligibility determination.

Under the Involuntary Treatment Act (ITA), counties or Regional Support Networks verify all ITA claims and utilize an ITA Patient Claim Information form to ensure that the billing is for services to a consumer involuntarily detained under Chapter 71.05 RCW. A provider submits a claim to the MMIS with the ITA Patient Claim Information form attached. MAA enters the eligible ITA client into the MMIS, and processes the associated claim. Another valid condition occurs when Medicaid applicants apply for Take Charge eligibility at a clinic or agency of an approved Take Charge provider. Providers assist the client in filling out the application and submit the application to MAA's Take Charge Eligibility Unit.

Auditor's Concluding Remarks

We appreciate the Department's attempts at resolving some of the issues in this finding.

The federal regulations are clear in the requirement that each individual (including children) requesting Medicaid services furnish his or her Social Security number. State agency regulations (WACs) cannot override federal regulations regarding the use of federal funds.

Individuals the Department identified as undocumented aliens were not included in our sample. Clients who were admitted into the Medicaid Program under the Involuntary Treatment Act were not counted as exceptions if they had Social Security numbers. However, it should not be relevant how the client is admitted into the Program as long as the requirements for eligibility are met. Our testing revealed that the Department's current controls do not always ensure this.

Applicable Laws and Regulations

The Code of Federal Regulations is explicit regarding obtaining and verifying Social Security numbers as a condition of Medicaid eligibility. 42 CFR 435.910 (a) specifically states in part:

> The agency must require, as a condition of eligibility that each individual (including children) requesting Medicaid services furnish each of his or her own social security numbers . . . .

42 CFR 435.910 (g) states:

> The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

If a Medicaid applicant cannot remember or has not been issued a Social Security number, 42 CFR 435.910 (e) (1-3) states that the agency must:

(1) Assist the applicant in completing an application for an SSN;

(2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and

(3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

42 CFR 435.916 (a) states in part:

> The agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months . . .

42 CFR 435.920 (a-c) states:

(a) In re-determining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.

(b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of 435.910.

If the agency initially established eligibility without verification of the Social Security number, 42 CFR 435.920 (c) requires:

> For any recipient whose SSN was established as part of the case record without evidence required under the SSN regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

The Medicaid State Plan incorporates the above references as applicable to Washington State's coverage and eligibility criteria when it states the following:

> The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

04-12 The Department of Health and the Department of Social and Health Services, Medical Assistance Administration, are not complying with state law or the provisions of the Medicaid State Plan that help to ensure compliance with health and safety standards for hospitals.

Background

In addition to other sources of revenue, hospitals statewide received more than $600 million in state and federal Medicaid funds in the calendar year 2003 for services provided to Medicaid clients. To be eligible for federal reimbursement, federal regulations require states to ensure that the facilities meet prescribed health and safety standards. To help meet these regulations, the Administration has included in the Medicaid State Plan a provision for surveys of hospital activities. The Department of Social and Health Services, Medical Assistance Administration, relies on the Department of Health to perform these surveys.

In the Plan, the Administration cites the state law that requires the Department of Health to complete these surveys annually. To avoid duplication, the law allows some survey exceptions when certain other professional organizations have performed recent, comparable surveys and reported the results to the Department. Hospitals receiving such surveys must then request exclusion from the state surveys.

In our fiscal year 2003 State Accountability Report, we reported that the Department of Health was not performing annual hospital surveys. Of 109 participating hospitals, only 61, or 56 percent, had received the required survey performed by the Department or by other qualifying professional organizations. We also reported in management letters that:

- The Department of Social and Health Services had not established a written agreement with the Department of Health for survey activities as required by federal regulation.

- The Department of Health did not comply with federal regulations regarding survey documentation.

Description of Condition

We reviewed the above areas during our current audit to determine whether progress had been made in correcting the conditions. We found that the Department of Health submitted legislation for the 2005 Legislative session, which, if passed, will increase the requirement period for hospital surveys from one year to 18 months. In addition, this proposed legislation requires a hospital to inform the Department if a survey is performed by another qualifying professional organization.

However, during fiscal year 2004, the Department of Health did not perform annual hospital surveys as required by current state law. Of the state's 102 current hospitals, we found only 50, or 49 percent, were evaluated by the Department or by one of the other qualifying professional organizations during calendar year 2003. The remaining 52 hospitals were not surveyed at all during this time.

The Administration has drafted an amendment to the State Plan that conforms to the state's current survey activity, increasing the required time period between surveys to a longer but indefinite amount of time. The Administration has not provided us with confirmation that the amendment has been submitted to or approved by the federal grantor.

The Department of Health and the Medical Assistance Administration have recently signed a Memorandum of Understanding for survey activities. However, this document does not meet all federal requirements. For example, it does not specify the types of surveys the Department must conduct or the documentation it must prepare.

Cause of Condition

The Department of Health stated it lacks sufficient staff to survey all hospitals on an annual basis. However, it believes its practices are sufficient for Medicare regulations and therefore are sufficient for Medicaid, even though Medicaid regulations are more specific.

The Department and the Administration also do not believe the Memorandum of Understanding must specify how they will comply with all of the federal regulations.

Effect of Condition

The state is making significant payments to hospitals for services to Medicaid clients with little assurance that the services provided are meeting state health standards and regulatory requirements. Costs associated with the hospitals that were not surveyed during 2003 were at least $206,599,122. Of this, $103,299,561 was paid with federal funds and the remainder with state funds. The entire amount is included in the overall Program disclaimer.

Recommendation

We recommend the Department of Health continue efforts to pass legislation which will help both to ensure its compliance with state law regarding annual hospital inspections and to maintain facilities that meet federal and state health and safety standards.

We recommend the Department of Social and Health Services, Medical Assistance Administration:

- Seek federal approval for an amendment to the State Plan that will allow the Department of Health to perform hospital surveys in conformance with the state's actual survey activity.

- Modify the language of the interagency agreement with the Department of Health to include all provisions required by law.

Department of Health's Response

We concur with the finding by the State Auditor's Office with respect to the issue concerning legal compliance with the required frequency of hospital surveys. Following the State Auditor's finding in January of 2004, the department proposed legislation to be considered by the 2005 legislature that would change the requirements for hospital surveys from yearly to every eighteen months. Governor Locke has approved moving forward with the department's requested legislation.

Additionally, DOH initiated a pilot of a modified survey process in September 2004. The objective is to improve efficiencies through focused surveys that reduce the staff time needed to complete the required hospital inspections. The expected savings will not be fully realized until a full survey cycle has been completed.

Thank you for the professional work by your staff.

Auditor's Concluding Remarks

We appreciate the Department's assistance and cooperation during our audit and its efforts to address this finding. We will review progress toward resolving this issue during our next audit.

Department of Social and Health Services' Response

The Department does not concur with this finding.
SAO originally described this condition to the Department in the 2003 State of Washington Single Audit Management Letter. Since then, the Department has obtained approval from the Center for Medicare & Medicaid Services (CMS) in our State Plan Amendment. The Department is also updating the current Memorandum of Understanding (MOU) with the Department of Health (DOH). Given these actions, we question why the SAO should cite this issue as a finding.
In the 2003 management letter, SAO was provided the following clarifications from the Center for Medicare & Medicaid Services (CMS):

- *The State Plan is not representative of "contemporary practice" as it pertains to survey frequency. As written at that time, the State Plan for hospital survey and certification was outdated and needed revision.*

- *The Medicare contract with DOH is not as rigorous as the Code of Federal Regulations regarding survey documentation requirements. CMS conceded that the SAO uncovered inconsistencies between the federal*

statute and the current practice delineated in the State Operations Manual. However, exception-based reporting is the "current practice" and the method of reporting approved by the State Operations Manual for Medicare. This manual is applicable to Medicaid as well

- *In general, CMS asserted that the survey practices in Washington regarding survey and certification activities for frequency and documentation for general hospitals are acceptable and that DOH, in fulfilling its responsibility for Medicare certification surveys, was simultaneously fulfilling its responsibility for Medicaid as well.*

DSHS has successfully completed revisions to the language in Attachment 4.11-A of the State Plan. This revision was approved by CMS on November 1, 2004, and was effective July 1, 2004. This means the state's survey and certification activities meet the full expectations of the federal funding agency. In addition, the Department is continuing to work with DOH to ensure that the MOU is consistent and compliant with state and federal requirements.

Auditor's Concluding Remarks

The Washington State Plan is on the Center for Medicare & Medicaid Services website at http://www.cms.hhs.gov/medicaid/stateplans/toc.asp?state=wa It has not been updated since October 25, 2000. The amendments are also on the same website at http://www.cms.hhs.gov/medicaid/stateplans/spa/wa.asp?state=wa This website was updated as of October 15, 2004.

Knowing that this website is not updated regularly, we asked the Department for any revisions with respect to this issue. We reviewed the only change provided and found only minor modifications were made. These do not change the content as it relates to hospital survey activities. The changes are as follows:

- The addition of the Department of Health as one of the agencies responsible for establishing and maintaining health standards. (This has never been an item of disagreement between the Department and the State Auditor's Office.)

- Updating the current name of the federal Centers for Medicare and Medicaid Services from its former designation as Health Care Financing Administration.

- The deletion of section 4.11 (d), which erroneously claimed that the Department was responsible for licensing health institutions. It had stated:

> The Department of Social and Health Services (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

In its response, the Department cited attachment 4.11-A. The State Plan on the website above includes this attachment and still states that RCW Chapter 70.41 is applicable. This regulation requires annual hospital inspections. We received no evidence that attachment 4.11-A has been amended to release the Department from following RCW 70.41 and monitoring to ensure that hospitals serving Medicaid clients are surveyed annually.

The revisions we have seen to the Memorandum of Understanding between the Department of Social and Health Services and the Department of Health do not conform to the provisions specifically required in the Code of Federal Regulations.

We reaffirm our finding that the Department of Health and the Department of Social and Health Services are not complying with state law or the provisions of the Medicaid State plan that help to ensure compliance with health and safety standards for hospitals.

Applicable Laws and Regulations

In describing the authority of the Medicaid State Plan, Title 42 of the Code of Federal Regulations, Section 430.10 states:

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

The Department of Social and Health Services acknowledges the authority of the State Plan and announces its commitment to abide by it in section 1.1 of the State Plan:

> As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Department of Social and Health Services submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

The State of Washington's Medicaid State Plan, page 42, states:

> 4.11 Relations with Standard-setting and Survey Agencies
>
> (a) The State agencies utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions . . . that provide services to Medicaid recipients. These agencies are: the Department of Social and Health Services and the Department of Health.
>
> (b) The State authority (ies) responsible for establishing and maintaining standards, other than those relating to health, for public and private institutions that provide services to Medicaid recipients are: the Legislature, State Board of Health, State Fire Marshall, the Department of Social and Health Services, and the Department of Health.
>
> (c) Attachment 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are on file and made available to the Center for Medicare and Medicaid Services on request.

Attachment 4.11-A states:

> The standards specified in paragraphs (a) and (b) on Page 42 of the Plan are as follows:
>
> A. General Hospitals Revised Code of Washington Chapter 70.41 . . . .

Regarding the Department of Health, RCW 70.41.120 states in part:

> The department shall make or cause to be made at least yearly an inspection of all hospitals . . . The department may make an examination of all phases of the hospital operation necessary to determine compliance with the law and the standards, rules and regulations . . . .

RCW 70.41.122 states in part:

> . . . a hospital accredited by the joint commission on the accreditation of health care organizations or the American osteopathic association is not subject to the annual inspection provided for in RCW 70.41.20 if:

(1) The department determines that the applicable survey standards of the . . . commission . . . or the . . . association are substantially equivalent to its own;

(2) It has been inspected by the . . . commission . . . or the . . . association within the previous twelve months; and

(3) The department receives directly from the . . . commission . . . , the . . . association, or the hospital itself copies of the survey reports . . . demonstrating that the hospital meets applicable standards.

42 CFR 431.610(f) states in part:

Written agreement required. The plan must provide for a written agreement between the Medicaid agency and the survey agency . . . covering the activities of the survey agency in carrying out its responsibilities. The agreement must specify that:

(1) Federal requirements and the forms, methods and procedures that the Administrator designates will be used to determine provider eligibility and certification under Medicaid;

(2) Inspectors surveying the premises of a provider will

(i) Complete inspection reports;
(ii) Note on completed reports whether or not each requirement for which an inspection is made is satisfied;
(iii) Document deficiencies in reports

(3) The survey agency will keep on file all information and reports used in determining whether participating facilities meet Federal requirements;

(4) The survey agency will make the information and reports required under paragraph (f) (3) of this section readily accessible to HHS and the Medicaid agency as necessary

(i) For meeting other requirements under the plan;
(ii) For purposes consistent with the Medicaid agency's effective administration of the program.

04-13 The Department of Social and Health Services, Medical Assistance Administration does not ensure that providers of motorized wheelchairs have the documentation required to substantiate claims for payment.

Background

Durable medical equipment is equipment that can withstand repeated use, is primarily used for a medical purpose, is generally used by a person with injury or illness, and is appropriate for use in the home. Some durable medical equipment, such as canes, walkers, crutches and wheelchairs, can give a person more mobility and greater independence.

An April 2004 report of the U. S. General Accounting Office (GAO) stated Medicare spending for power wheelchairs, one of the program's most expensive items of equipment, rose 450 percent from 1999 through 2003. However, Medicare has reported only an 11 percent increase in overall spending for the same period. This spending growth for power wheelchairs has raised concerns that Medicare may have made improper payments to providers of motorized wheelchairs.

These concerns may apply to Medicaid, which also pays claims for power wheelchairs. Between January 1 and December 31, 2003, the state Medicaid program paid over $1 million to 104 providers for motorized wheelchairs with programmable controls.

In this state, a Medicaid provider must obtain specific documentation to substantiate a patient's need for such a wheelchair. This documentation includes a prescription signed by a physician or other licensed health practitioner, proof of medical necessity, and the patient's confirmation of delivery. In addition, prior authorization by the Administration is required for some wheelchair claims as follows:

- Provider claims with five or more line items to be paid totally by Medicaid require support documentation prior to authorization.

- Provider claims with less than five line items may be communicated by phone prior to authorization. However, written documentation eventually must be provided.

Claims paid by both Medicare and Medicaid, with Medicare as the primary payer, require no prior authorization.

According to Medicaid eligibility requirements, the estimated length of need for a patient cannot exceed six months; after that time, the need must be re-evaluated.

Description of Condition

We attempted to determine compliance with the documentation requirements for providers of motorized wheelchairs. Because the Department of Social and Health Services, Medical Assistance Administration, does not receive or maintain these records, we performed on-site reviews of the payment support documentation for 90 claims submitted by three providers of power wheelchairs.

While all of the claims tested had the required proofs of delivery, none of the three providers was able to produce all of the other required documentation to substantiate their claims for payment by Medicaid.

- None of the 90 claims had prescriptions that conformed to all Medicaid requirements.

- Nine of the 90 claims did not have the required proofs of medical necessity.

- Additionally, all of the documents we reviewed indicated a length of need exceeding six months, but we found no indications that reevaluations were done.

Cause of Condition

- Providers of power wheelchairs may be unsure of the documentation required for payment, due to the difference in the support requirements between Medicare and Medicaid.

- The Administration has no standardized forms for prescriptions and proof of medical necessity for providers.

- While the Administration stated it reviews a selected number of wheelchair claims, it does not review any claims paid by both Medicare and Medicaid**.** In an e-mail to our office, the Administration stated:

> The primary reason for this is that Medicare . . . payment and coverage rules are significantly different from Medicaid. If Medicaid were to include crossover claims in an audit or post-payment review sample, those claims could not be reviewed per Medicaid rules/billing instructions. Medicaid auditors lack the detailed knowledge of the Medicare program and the authority to audit Medicare paid claims.

Effect of Condition

This condition increases the risk that providers could submit fraudulent requests for payment that would not be detected in a timely manner, if at all. The cost associated with the ninety claims we tested was $115,282, of which $57,641 was paid with federal funds and an equal amount with state funds. The entire amount is included in the overall Program disclaimer.

Recommendations

We recommend that the Administration:

- Ensure its providers are familiar with the differences in documentation requirements for Medicare and Medicaid.

- Standardize prescription and proof of medical necessity forms to facilitate compliance by providers.

- Establish controls to perform adequate reviews of payment support documentation prior to making payments for motorized wheelchairs. Ensure reviews include verification of allowability for the Medicaid portion of costs paid for with both Medicaid and Medicare funds.

- Work with the U.S. Department of Health and Human Services to determine if any unsupported costs charged to Medicaid must be returned.

Department's Response

The Department does not concur with this finding.

Medical Assistance Administration (MAA) currently reviews Medicaid-only requests for wheelchairs through a prior authorization process, and files are kept.

- *The 90 claims reviewed by the auditors appear to be claims that involved dual-eligible clients (enrolled in both Medicare and Medicaid). Those claims are paid through our system as a "Medicare cross-over" – claims that are only reimbursed for applicable co-pays and deductibles -- and no prior authorization review is performed. Suppliers are bound by primary payer rules – in these cases, Medicare-- <u>not</u> Medicaid.*

- *Since these claims were paid as a Medicare cross-over, the Department feels that the suppliers met their documentation and billing requirements as defined by Medicare as a primary payer and Medicaid as a secondary payer.*

- *There is no length-of-need requirement in federal guidelines. The eligibility requirements cited by SAO with regard to length-of-need appear to be a misreading of the Washington Administrative Code. As written, WAC 388-543-1100 (1d) refers to a period not to exceed six months, but the reference actually means the client's condition should be re-evaluated after six months. It would be counterintuitive to interpret the reference to mean the Department will only buy wheelchairs for clients whose need is temporary. In fact, the Department requires the opposite – i.e., the need for a power wheelchair must exceed six months before it can be purchased.*

  The Administration reviews every request for a Medicaid-only client through a prior authorization process. The reports should differentiate which statements refer to a payment for a Medicare/Medicaid client and which statements refer to a Medicaid-only client. The Department is in the process of developing a standardized prescription form to be used for requests from Medicaid-only clients. We also will look at the need to have a standardized proof-of-delivery form.

  The SAO appears to be recommending a prior authorization or pre-pay process be developed for dual-eligible clients as well as Medicaid-only clients. The Department feels additional research would be needed to determine whether that would be cost effective.

  Given this additional information, the Department is unsure of what expenditures need to be recovered.

Auditor's Concluding Remarks

We agree that Medicare and Medicaid are separate payers and that the requirements for reimbursement may be different for each. We do not agree that providers are bound solely by primary payer rules, in this case Medicare, when a portion of the payment is made with Medicaid funds. Since the requirements for payment with Medicaid funds are different from those of Medicare, the Department is under an obligation to ensure that the Medicaid conditions are met.

State administrative code (WAC 388-543-1100), cited below in the section on Applicable Laws and Regulations, states the federal government considers durable medical equipment to be optional services under the Medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment program. The documentation requirements are specific to ensure that these criteria are met. The regulations regarding the length of need in part (d) are clear. During our testing, Department staff agreed that the prescription requirements were not being met. To avoid this situation in the future, the Department reported that it may remove the requirements.

Ensuring the requirements for the Medicaid portion of a Medicare-crossover claim is the responsibility of the Medicaid Program, not the Medicare Program. We reaffirm our finding and recommendations.

Applicable Laws & Criteria

WAC 388-543-1225 states:

Provider requirements.

(1) Providers and suppliers of durable medical equipment (DME) and related supplies, prosthetics and orthotics, medical supplies and related items must meet the general provider documentation and record retention requirements in WAC 388-502-0020. In addition to these requirements, the medical assistance administration (MAA) requires providers to furnish, upon request, documentation of proof of delivery as stated in subsections (2) and (3) of this section.

(2) When a provider delivers an item directly to the client or the client's authorized representative, the provider must be able to furnish proof of delivery when MAA requests that information. All of the following apply:

(a) MAA requires a delivery slip as proof of delivery, and it must:

(i) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received);
(ii) Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name; . . . .

WAC 388-502-0100 states:

General conditions of payment.

(1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

(a) The service is within the scope of care of the client's medical assistance program;
(b) The service is medically or dentally necessary;
(c) The service is properly authorized;

WAC 388-543-1100 states:

Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services.

The federal government deems durable medical equipment (DME) and related supplies, prosthetics, orthotics, and medical supplies as optional services under the Medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (EPSDT) program. The department may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(1) The medical assistance administration (MAA) covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when all of the following apply. They must be:

(a) Within the scope of an eligible client's medical care program;
(b) Within accepted medical or physical medicine community standards of practice;
(c) Prior authorized as described in WAC 388-543-1600;
(d) Prescribed by a qualified provider, acting within the scope of the provider's practice. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity;
(e) Billed to the department as the payor of last resort only. MAA does not pay first and then collect from Medicare; . . .

(10) MAA covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician or other licensed practitioner of the healing arts, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:

(a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;
(b) Wheelchairs and other DME; . . . .

04-14 The Department of Social and Health Services, Medical Assistance Administration does not perform adequate reviews of providers of durable medical equipment to ensure the providers exist, are properly licensed, and have submitted accurate information.

Background

Durable medical equipment is equipment that can withstand repeated use, is primarily used to serve a medical purpose, generally is used by a person with injury or illness, and is appropriate for use in the home. Examples include, among other items, hospital beds, wheelchairs, and oxygen delivery systems**.**

Providers of this equipment must be approved by the Department of Social and Health Services, Medical Assistance Administration. These providers submit documentation to the Administration to verify they are able to supply certain products. Required documents include business licenses and completed agreements between the Administration and providers. The Administration is responsible for reviewing the information prior to establishing a provider number for an individual or organization. This number, when accompanied by a claim, causes the Administration's system to generate an approval and payment to the provider.

Description of Condition

We attempted to determine whether the reviews performed by the Administration were adequate to ensure the existence of an entity prior to the establishment of a provider number. We found the Administration does not:

- Verify the provider's business phone number and address.
- Verify the validity and status of the business license.
- Provide criteria for the circumstances that constitute a valid business license for in- and out-of-state providers.
- Program its Medicaid Management Information System to notify staff members when business licenses expire. Currently, this function is operative for professional licenses only.

Due to the weaknesses we found, we expanded our scope and conducted a review of providers in Washington and in the border states of Oregon and Idaho to determine if there was reasonable assurance the businesses existed and were operating. We reviewed the Administration's records for 80 providers and conducted site visits for 25 of those providers. As a result of the site visits, we found:

- Five businesses had ceased operations, but the Administration had not terminated their provider numbers.
- Two businesses could not be located. One was an in-state provider and the other an out-of-state provider.
- Two businesses appeared to be private residences. It is difficult to determine if business is actually conducted on these premises.
- Three businesses had changed ownership without reporting the changes to the Administration as required by the Core Provider Agreement.
- Three businesses were listed as inactive on the Department of Licensing or Department of Revenue's Websites. These businesses did have active city licenses.
- Six businesses had changed address and/or phone numbers but had not reported the changes to the Administration.
- Two providers had expired licenses

We asked for additional information for 13 of the 80 providers we reviewed. We found that the Administration had out-dated licensing information for 12 of the 13**.**

Cause of Description

The Administration stated a lack of resources prevents it from performing a thorough review of provider enrollment information. Currently, the Administration has only three staff members performing the enrollment functions for over 28,000 providers. Additionally, the Administration has not clearly set forth for staff the procedures required to ensure whether a business is properly licensed and operating.

Effect of Condition

While we found no inappropriate payments made to these particular providers, these weaknesses could allow providers to submit fraudulent requests for payment that would not be detected in a timely manner, if at all. Because of the costs involved with durable medical equipment, such payments could result in significant losses in a relatively short period of time.

Recommendations

We recommend the Administration:

- Establish clearly defined policies and procedures to ensure adequate verification of provider information.
- Provide the resources necessary to perform adequate review of provider information prior to establishing a provider number.
- Program the Medicaid Management Information System to identify expired business licenses.
- Monitor providers for compliance with Core Provider Agreements.

Department's Response

The Department partially concurs with this finding.

- *We do not believe the weaknesses cited in the sample of 25 providers out of approximately 1,600 durable medical providers would result in significant losses because of compensating internal controls that are currently in place. For instance, if correspondences and/or payments are sent to an incorrect address, they are automatically returned to the Medical Assistance Administration (MAA) by the U.S. Postal Service. Staff would then research and update for any address changes or corrections. If MAA is unable to obtain an updated address, then the provider agreement is terminated. When ownership changes, the new owner must contact the Department to ensure that future payments are made to the new owner. At that time, the new owner must sign a new Core Provider Agreement in order to be paid, and MAA staff terminates the previous owner's agreement. Finally, it is important to note that the MAA has staff in the Post Payment Review and Audit sections whose sole responsibility is to perform post-payment reviews and ensure that any inappropriate payments are recouped in a timely manner. Furthermore, it is our opinion that the clerical errors cited by the SAO are errors that staffs would have taken care of during the normal course of business.*
- *WAC 388-543-1200, contains no requirement that durable medical equipment (DME) providers have storefronts. Legitimate businesses may operate out of a residence.*
- *The SAO cited WAC 388-502-0010, "(1) To be eligible for enrollment, a provider must: (a) Be licensed…according to Washington state laws and rules . . . " However, WAC 388-543-1200 (1) (a) requires DME providers to have "the proper business license." The Department accepts both city and state business licenses as proper business licenses.*

- *As a good business practice, the Department will explore confirmation of licensing by partnering with the Department of Revenue. DSHS and the Department of Health also will investigate the verification of providers' business locations and phone numbers through a reverse directory search. Also, we acknowledge that our current Medicaid Management Information System (MMIS) does not identify expired business licenses. This is another among the many reasons why a reprocured MMIS will benefit the state. The new MMIS will allow us the ability to include the verification of both business and professional licenses.*

Auditor's Concluding Remarks

The review we performed was a judgmental selection of 25 out of 80 providers. We did not sample or pull our test selection from all 1,600 providers as the Department's response indicates. Rather, we conducted reviews for providers in Eastern Washington and the border states of Oregon and Idaho, where we assessed the risk to be highest. Our exceptions were derived from only 5 percent of the total population of durable medical equipment providers. However, given the weaknesses in controls described in the section titled Description of Condition, which are applicable to all 1,600 providers, similar results may have been found in the remaining providers, had we tested them.

Significant loss of taxpayer money can occur even when inappropriate payments are identified in the post-payment review process. Costs for investigation and recovery, if possible, are often sizeable and may far exceed the costs of prevention. Pre-payment reviews and verifications would greatly reduce the risk of misappropriation and other inappropriate payments.

The compensating control of address correction requests to the U.S. Postal Service appears to be ineffective. We found that Department records contained inaccurate licensure, location and phone information for some providers that appeared to be long- standing. Following our review, the Department terminated 6 percent of the providers tested due to the lack of information needed to justify their active status.

We disagree with the Department's position that its current reviews are sufficient to prevent loss. In one recent case, the Department experienced a loss in excess of $180,000 over a two-year period from one provider of durable medical equipment.

The sale of durable medical equipment is taxable. The lack of a state business license could allow a provider to avoid paying these taxes, without detection, for an indefinite period of time. This would prevent agencies such as the Department of Revenue from collecting the legally-owed sales taxes for what could be significant revenues.

We reaffirm our finding that the Department's current internal controls are not adequate and that the potential for misappropriation is significant.

Applicable Laws and Regulations

The U.S. Office of Management and Budget Circular A-133 *Compliance Supplement* states:

> In order to receive Medicaid payments, providers of medical services furnishing services must be licensed in accordance with Federal, State, and local laws and regulations to participate in the Medicaid program . . . and the providers must make certain disclosures to the State . . . .

Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart C, Section .300 states:

> The auditee shall: . . .
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulation, and the provision of contracts or grant agreements that could have a material effect on each of its Federal programs . . .

Section 20.20.20.a of the State Administrative and Accounting Manual states, in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

The Core Provider Agreement, paragraph 4 c., states in part:

> . . . the Provider agrees to notify the Department of any material and/or substantial changes in information contained on the enrollment application given to the Department by the Provider. This notification must be in writing within thirty (30) days of the event triggering the reporting obligation. Material and/ or substantial changes include, but are not limited to changes in:
>
> a. Ownership
> b. Licensure
> e. Any change in address or telephone number

WAC 388-502-0010 states in part:

> The Department reimburses enrolled providers for covered medical services, equipment and supplies they provide to eligible clients.
>
> (1) To be eligible for enrollment, a provider must:
>
> (a) Be licensed, certified, accredited, or registered according to Washington state laws and rules; . . .

04-15 The Department of Social and Health Services, Medical Assistance Administration, does not have adequate internal controls in its Medicaid Management Information System to prevent payments to providers with expired licenses.

Background

The Department of Social and Health Services, Medical Assistance Administration is responsible for the Medicaid Management Information System (MMIS), a computer system that processes most of the state's Medicaid claims. In calendar year 2003, MMIS processed more than $3 billion in over 35 million transactions. The Department contracts with a vendor for MMIS services, including current system management, records retention, data security and maintenance of system files, programs and documentation. Most of the changes to the system's programming are performed by the vendor at the Administration's request.

The MMIS identifies two types of providers:

- Billing providers are those receiving payments for services. These types of providers are practice groups or independent individual practitioners. These providers are assigned numbers, and MMIS is programmed to recognize these numbers as having been approved for payment.

- Performing providers are part of a practice group. They perform services under the billing provider's number. They are enrolled in the system in this way so the Administration can identify which practitioners are rendering services to its clients and with which billing providers they are associated. Performing providers do not receive payments. Instead, the billing provider with whom they are associated receives payment for the services the performing providers rendered as members of the group. MMIS is programmed to automatically deny any claims submitted by performing providers as individuals.

Description of Condition

We found there are no system checks in MMIS that will prevent payment to a billing provider when the license of one of its performing providers has expired. MMIS tracks license expiration dates for both billing providers and performing providers. The Administration enters the termination code "C" into provider files to identify providers whose licenses have expired. This code should prevent providers from being paid for procedures they are not eligible to perform because their licenses have expired. We found, however, that MMIS continues to pay claims to the billing provider even when the termination code "C" has been entered for one of its performing providers.

Cause of Condition

MMIS has not been programmed to automatically deny a claim of a billing provider when the license of one of its performing providers has expired.

Effect of Condition

This internal control weakness could allow billing providers to be paid for services rendered by unlicensed practitioners within their groups. Federal and state funds cannot be used to pay for services rendered by practitioners who are not properly licensed.

Recommendations

We recommend the Administration establish controls to ensure it does not reimburse a billing provider for claims submitted for services performed by its unlicensed performing providers.

Department's Response

The Department concurs with this finding.

> *Identification of this control weakness is appreciated, and the Department is initiating systems modifications that will deny claims for any services delivered by an unlicensed performing provider (termination code "C").*
>
> *As a clarification, billing providers and performing providers are distinguished by the data field submitted on a claim, not by any distinction in the Medicaid Management Information System (MMIS). Although there are some providers designated in the MMIS as "ID Only" (not a "pay to" provider) the general rule is that the billing and performing providers are identified by the data field. The MMIS will deny claims where an ID Only provider submits as the billing provider. However, there are many instances where the billing and performing providers are the same. In such cases, the MMIS pays these as individual performing providers.*

Auditor's Concluding Remarks

We appreciate the Department's efforts to resolve the issues identified in the finding. We will review the controls that the Department has instituted during our next audit.

Applicable Laws and Regulations

The U.S. Office of Management and Budget's *Circular A-133 Compliance Supplement* states in part:

> In order to receive Medicaid payments, providers of medical services furnishing services must be licensed in accordance with Federal, State, and local laws and regulations to participate in the Medicaid program . . . .

Circular A-133, *Audits, of States, Local Governments, and Non-Profit Organizations*, Subpart C, Section .300 states:

> The auditee shall: . . .
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs . . . .

The state Office of Financial Management's *State Administrative and Accounting Manual,* Section 20.20.20.a states, in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

WAC 388-502-0010 states in part:

> The Department reimburses enrolled providers for covered medical services, equipment and supplies they provide to eligible clients.
>
> (1) To be eligible for enrollment, a provider must:
>
> (b) Be licensed, certified, accredited, or registered according to Washington state laws and rules; . . .

04-16 The Department of Social and Health Services' Medical Assistance Administration and the Office of Accounting Services have not complied with federal regulations requiring the federal portion of cancelled warrants to be refunded to the Medicaid Program.

Background

Approximately 80 percent of Medicaid payments are made with warrants issued by the Medical Assistance Administration. Some warrants to providers are issued in error and are to be cancelled as soon as errors are discovered. When this occurs, the amount provided by the federal government must be refunded to Medicaid in the quarter the warrant is cancelled. Interest penalties accrue on transactions greater than $50,000 that are not refunded within the appropriate quarter.

The Medical Assistance Administration is responsible for processing erroneous warrants through the Medicaid Management Information System and creating a tape which is sent to the Office of Accounting Services. The Office is responsible for creating the automated journal voucher which will cancel the warrant in the state's Agency Financial Reporting System (AFRS). The Office is to notify the State Treasurer's Office of the cancellation.

Description of Condition

We reviewed the Administration's procedures and found warrants that should have been cancelled were instead re-entered by the Office as expenditures through the use of incorrect transaction codes. We reviewed four journal vouchers during a ten-month period and found $466,852 in warrants, rather than being cancelled, were entered erroneously as expenditures again, for a combined total of $933,705. Half of this amount, or $466,852, was provided by federal funds.

At the time of our audit, the Department was 336 days late in refunding the money to the federal Medicaid Program. In addition, the state portion of the amount was still identified as expenditure, rather than as cancelled warrants.

Cause of Condition

- Neither the Administration nor the Office know why the incorrect transaction was used.
- No one monitored to determine if the cancellations had been entered correctly into the system.
- No one manager in the Administration is responsible for overseeing the entire warrant cancellation process.
- Communications between the Accounting Office and the Administration are ineffective.
- Neither the Office nor the Administration believes it is responsible for the automated journal vouchers.

Effect of Condition

By doubling the amount of erroneous expenditures, the Department has doubled the amount of the federal reimbursements to which it was not entitled... The state funds still shown as expenditures rather than as warrant cancellations are unavailable for other purposes. The total of $933,705 in state and federal funds is included in the overall Program disclaimer. The Department also owes interest of $5,585 on half that amount ($466,852) to the federal government.

Recommendations

We recommend the Department:

- Cross train staff in all aspects of warrant cancellation and the refunding process, including the importance of checking error reports.
- Designate one manager or supervisor with responsibility and authority for the entire warrant cancellation process.

- Establish effective monitoring procedures to identify uncashed and cancelled warrants written with Medicaid funds and determine if proper refunding was accomplished.

- Reverse the expenditure of $933,705 from warrants issued in error. Reimburse the federal government $466,852 and interest liability of $5,585 related to the cancelled warrants the state has not yet refunded.

Department's Response

The Department partially concurs with this finding.

The error that caused the financial condition cited in this finding has been corrected. The federal funds have been remitted to the federal government through the federal draw process. This correction will also be noted on the Medicaid claim (CMS-64) for the quarter ending December 31, 2004.

The transactions reviewed in this finding covered a four-week period that was afflicted by system problems, However, as a result of this review, the Office of Accounting Services (OAS) has established more effective monitoring procedures to ensure Medicaid Management Information System (MMIS) warrant cancellations are processed correctly. OAS has designated one manager to oversee the Agency Financial Recording System (AFRS) error reporting process and is reviewing its current procedures to determine if some controls can be strengthened. OAS is also working to improve its communications with MAA warrant cancellation staff. Because of the complexity and multitude of warrant-generating systems at DSHS, it is impossible at this time to designate one manager with the responsibility and authority for the entire warrant cancellation process.

The Department does not agree with the following Cause of Conditions noted in the finding:

- ***Cause of Condition – First Bullet:*** *The Department uses an automated process to cancel warrants issued from the MMIS. When Medical Assistance Administration (MAA) staff cancels warrants in MMIS, a file is generated that is converted into a format, including the addition of transaction codes compatible with the Agency Financial Reporting System (AFRS). During this four-week period, coding errors in this process generated transaction codes that caused the questioned transactions to be entered into AFRS as expenditures instead of cancellations. These coding errors were easily identified and corrected so that the system now appropriately records warrant cancellations in AFRS.*
- ***Cause of Condition – Fifth Bullet:*** *The Information Technology Office (ITO) of the Financial Services Administration maintains and operates the automated process that converts cancelled MMIS warrants into AFRS format. OAS maintains oversight of the process and coordinates with MAA and ITO staff to ensure the process is functioning correctly.*

Auditor's Concluding Remarks

We appreciate the efforts that the Department has made to resolve some of the issues identified in the finding.

We did not review all the journal vouchers that were processed during the fiscal year. We selected four during a 10-month period. Therefore, other transactions may have been improperly coded.

Applicable Laws and Regulations

Title 42, Code of Federal Regulations, Section 433.40 states in part:

(d) **Refund of FFP for cancelled (voided) checks-**

(1) General provision. If the State has claimed and received FFP for the amount of a cancelled (voided) check, it must refund the amount of FFP received.

(2) Report of refund. At the end of each calendar quarter, the State agency must identify those checks which were cancelled (voided). The State must refund all FFP that it received for cancelled (voided) checks by adjusting the Quarterly Statement of Expenditures for that quarter.

(3) If the State does not refund the appropriate amount as specified in paragraph (d)(2) of this section, the amount will be disallowed.

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, states in Attachment A, Section C.4.a:

> Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are: purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments of overpayments or erroneous charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

Title 31of the Code of Federal Regulations describes the Treasury-State agreement known as the Cash Management Improvement Act and includes the Medicaid program. Section 205.15 states in part:

When does State interest liability accrue?

(a) General rule. State interest liability may accrue if Federal funds are received by a State prior to the day the State pays out the funds for Federal assistance program purposes. State interest liability accrues from the day Federal funds are credited to a State account to the day the State pays out the Federal funds for Federal assistance program purposes.

(b) Refunds.

(1) A State incurs interest liability on refunds of Federal funds from the day the refund is credited to a State account to the day the refund is either paid out for Federal assistance program purposes or credited to the Federal government.

(2) We and a State may agree, in a Treasury-State agreement, that a State does not incur an interest liability on refunds in refund transactions under $50,000 . . . .

(d) Mandatory matching of Federal funds . . . A State incurs interest liabilities if it draws Federal funds in advance and/or in excess of the required proportion of agreed upon levels of State contributions in programs utilizing mandatory matching of Federal funds with State funds.

04-17 The Department of Social and Health Services' Office of Accounting Services has not complied with federal regulations requiring the federal portion of uncashed warrants to be refunded to the Medicaid Program.

General Background

Approximately 80 percent of Medicaid payments are made with warrants issued by the Medical Assistance Administration. Some of the warrants to providers are never cashed, largely because the warrants cannot be delivered due to address changes. If a warrant remains uncashed beyond a period of 180 days from the date it was issued, it is no longer regarded as an allowable federal expenditure, even though the state still has a liability to the vendor. Such warrants are referred to as being beyond the Statute of Limitations. The amount that was provided by the federal government must be refunded to Medicaid in the quarter the warrant was cancelled. Interest penalties accrue on transactions greater than $50,000 that are not refunded within the appropriate quarter.

The State Treasurer's Office regularly updates its computer data to identify uncashed warrants that have reached the 180-day Statute of Limitations and will be automatically cancelled by the Treasurer. The Department's Office of Accounting Services is responsible for checking this information periodically and canceling the warrants through the state's Agency Financial Reporting System.

Description of Condition

We reviewed the Department's procedures for complying with these regulations and found the Office of Accounting Services had not reviewed the Treasurer's data and processed refunds from uncashed warrants since June 2003. When we finished our field work in May, the unprocessed refunds totaled $843,294. Half of this amount, or $421,647, was federal money that should have been refunded. At the time of our audit, the Department was 244 days late in refunding the money to the federal Medicaid Program.

Cause of Condition

The key employee who was primarily responsible for performing this function was away from the job on leave for an extended period of time. Office management stated it was aware of the situation but did not have sufficient staff to provide a replacement.

Effect of Condition

The Department still owes the federal government $421,647 in federal funds to which the state was not entitled. In addition, it owes interest of $2,093 on this amount. The combined federal and state funds of $843,294 in these uncashed warrants are included in the disclaimed amount in the overall Program disclaimer.

Recommendations:

We recommend the Department:

- Cross train staff in all aspects of warrant cancellation and the refunding process, including the importance of checking error reports.
- Establish effective monitoring procedures to identify uncashed and cancelled warrants written with Medicaid funds and determine if proper refunding was accomplished.
- Reimburse the federal government for the federal portion ($421,647) and interest liability ($2,093) related to the uncashed warrants that the state has not yet refunded. The total amount owed to the federal government is $423,740.

Department's Response:

The Department concurs with this finding.

DSHS issues millions of warrants to vendors, employees, and client payees per year. The statute of limitations (SOL) desk in the Office of Accounting Services (OAS) processes from several hundred to more than 1,000 SOL warrants per month. Statistically, the number of warrants that reach the 180-day SOL is small in comparison to those issued, although the dollars involved may be significant as noted in the finding above.

During the time of the audit, OAS was experiencing the loss of the key employee responsible for processing SOL warrants. The manager responsible for oversight of the SOL process saw this as an opportunity to develop new procedures to more rapidly clear SOL warrants. During the development of these procedures and the continued absence of the key employee, unprocessed SOL warrants began to accumulate, resulting in the condition expressed in this finding. Once new procedures were developed and a new employee assigned and trained in SOL processing, the backlog of SOL warrants was cleared. Even with these new procedures, there exists a systemic one-month lag that will require the development of additional systems and processes in order to reduce the amount of time that exists from the time we are notified of an SOL warrant to the completion of initial processing and refund of federal funds on that warrant.

Through an automated process, OAS now receives more timely electronic notification of SOL warrants from the Office of the State Treasurer. OAS is currently working on the timely retrieval of information from DSHS's multiple warrant-generating systems in order to facilitate more rapid SOL processing. The current process is very labor intensive and needs further automation. We are currently studying the SOL warrant process from top to bottom in an effort to make the process more efficient and effective.

Per the SAO's recommendations, OAS will cross-train additional staff to support processing SOL warrants. OAS will continue developing effective monitoring procedures to identify and ensure SOL warrants pertaining to Medicaid and all other funding sources are properly addressed so that refunds to federal programs occur in a timely manner. The SOL warrants in question have been processed and the resultant Medicaid funds have been refunded to the federal government through the federal draw process and are included in the 2004 Third Quarter Medicaid (CMS-64) and CHIPS (CMS-21) claims. (Documents to support this assertion are available for review.)

Auditor's Concluding Remarks

We appreciate the Department's efforts to resolve the issues identified in the finding. We will review the controls that the Department has instituted during our next audit.

Applicable Laws and Regulations:

Title 42, Code of Federal Regulations, Section 433.40 states in part:

(c) **Refund of Federal financial participation (FFP) for uncashed checks-**

(1) General provisions. If a check remains uncashed beyond a period of 180 days from the date it was issued; i.e., the date of the check, it will no longer be regarded as an allowable program expenditure. If the State has claimed and received FFP for the amount of the uncashed check, it must refund the amount of FFP received.

(2) Report of refund. At the end of each calendar quarter, the State must identify those checks which remain uncashed beyond a period of 180 days after issuance. The State agency must refund all FFP that it received for uncashed checks by adjusting the Quarterly Statement of Expenditures for that quarter . . .

(3) If the State does not refund the appropriate amount as specified in paragraph (c)(2) of this section, the amount will be disallowed.

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, states in Attachment A, Section C.4.a:

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(b) Refunds.

(1) A State incurs interest liability on refunds of Federal funds from the day the refund is credited to a State account to the day the refund is either paid out for Federal assistance program purposes or credited to the Federal government.

(2) We and a State may agree, in a Treasury-State agreement, that a State does not incur an interest liability on refunds in refund transactions under $50,000 . . .

(d) Mandatory matching of Federal funds...A State incurs interest liabilities if it draws Federal funds in advance and/or in excess of the required proportion of agreed upon levels of State contributions in programs utilizing mandatory matching of Federal funds with State funds.

04-18 The Department of Social and Health Services, Health and Rehabilitative Services Administration is not in compliance with the federal Medicaid requirements for reporting on adult victims of residential abuse.

Background

As a condition for receiving Medicaid funds, a state must establish and operate a State Medicaid Fraud Control Unit. The Fraud Unit must be a single identifiable entity of the state government and must be separate and distinct from the Medicaid agency. In Washington, Medicaid is administered by the Department of Social and Health Services, while the Medicaid Fraud Control Unit is administered by the Office of the State Attorney General.

The purpose of the Fraud Unit is to investigate and prosecute all Medicaid fraud-related violations. Federal regulations also require the Fraud Unit to review allegations of patient abuse in health care facilities that receive Medicaid payments. Residential abuse also includes neglect and financial exploitation of those in residential care.

The Attorney General's Office and the Department have an agreement requiring the Department to notify the Fraud Unit of all allegations of residential abuse. The agreement stipulates that the Department's Aging and Disability Services Administration shall immediately report to the Fraud Unit allegations of abuse in residential facilities receiving Medicaid funds. To accomplish this, other administrations within the Department must report allegations of residential abuse within their administrations to Aging and Disability Services in a timely manner.

Description of Condition

We found two divisions within the Health and Rehabilitative Services Administration were not complying with the residential abuse reporting requirements. The Division of Alcohol and Substance Abuse and the Mental Health Division's Western State and Eastern State Hospitals were not reporting allegations of residential abuse of vulnerable adults in their care to either Aging and Disability Services or directly to the Medicaid Fraud Control Unit. The Mental Health Division and the Division of Alcohol and Substance Abuse have their own procedures to investigate residential abuse, but the employees who oversee these activities are not independent of the division receiving Medicaid funds as required by the law.

Cause of Condition

- The Mental Health Division stated it was not aware of the reporting policy.
- The Division of Alcohol and Substance Abuse believes that federal confidentiality requirements prohibit it from reporting such allegations.
- While the Department's agreement with the Attorney General's Office specifies the Aging and Adult Services Administration will be the Department's central point of contact for reporting abuse allegations, the Department does not have an overall policy requiring its employees to report all cases of residential abuse to that Administration.

Effect of Condition

Because the Fraud Unit is not aware of all allegations of residential abuse of Medicaid patients, it is unable to perform its required investigatory role in all cases. This non-compliance with federal reporting requirements could jeopardize future federal funding.

In addition, this situation could expose vulnerable adults to long-term exploitation, abuse and neglect and could pose a financial liability to the state.

Recommendations

We recommend the Department:

- Establish and follow policies requiring all of its administrations serving vulnerable adults in residential care facilities receiving Medicaid funds to immediately report allegations of residential abuse to the Aging and Disability Services Administration.

- Ensure that Department policies reflect the reporting process stipulated in the agreement with the Attorney General's Office.

Department's Response

The Department concurs with the finding.

> *Western State Hospital (WSH), Eastern State Hospital (ESH) and Child Study and Treatment Center (CSTC) will include a statement in their patient abuse policy that the Medicaid Fraud Control Unit (MFCU) will be notified of any patient abuse, neglect and/or financial exploitation.*
>
> *The Division of Alcohol and Substance Abuse (DASA) will report to the Medicaid Fraud Control Unit (MFCU) complaints and incidents alleging abuse, neglect or misappropriation of the private funds of patients who receive Medicaid-funded services in DASA-certified residential chemical dependency treatment programs.*
>
> *DASA will request a court order to forward any information protected under 42 Code of Federal Regulations Part 2, regarding Confidentiality of Alcohol and Drug Abuse Patient Records, obtained during an on-site survey that could be evidence of abuse or neglect or misappropriation of the private funds of patients who receive Medicaid-funded services in a DASA certified residential chemical dependency treatment program.*

Auditor's Concluding Remarks

We appreciate the Department's efforts to resolve the issues identified in the finding. We will review the controls that the Department has instituted during our next audit.

Applicable Laws and Regulations

Title 42 of the Code of Federal Regulations, Section 1007.11 stipulates the residential abuse responsibilities of the fraud unit, stating in part:

> The unit will also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient's private funds in such facilities.

Section IV of the Memorandum of Understanding between the Department and the Attorney General's Office, Medicaid Fraud Control Unit (MFCU), executed in March 2000, states in part:

> The Department operating through AASA (Auditor's note: now Aging and Disability Services Administration) immediately shall make available to the MFCU allegations of resident abuse, neglect, and financial exploitation in residential care facilities receiving Medicaid funds.

04-19 The Department of Social and Health Services' Medical Assistance Administration and Division of Child Support have inadequate internal controls to ensure compliance with Medicaid requirements to identify third parties, usually insurance companies, responsible for payments for medical services.

Background

The federal government requires that states identify third party insurers responsible for paying for medical services for potential Medicaid clients. Federal regulations also require the enforcement of any child support order that states the noncustodial parent must provide health insurance for a child**.** The regulations state that, when a child receives benefits through the Medicaid program, the child support enforcement office, which in this state is the Division of Child Support Enforcement, must pass the insurance information to the state Medicaid office, in this case the Medical Assistance Administration. This procedure ensures the Medicaid office is aware there may be another source of insurance.

Description of Condition

When the Division began enforcing medical support in 1990, it used specific carrier codes to inform the Administration that insurance coverage was available to a child. The carrier code identified the insurance company by name, address and telephone number. Division staff members were expected to enter the proper carrier code into the Support Enforcement Management System, which could then be accessed by the Administration for use in contacting the carrier to determine the coverage available to the child.

If the Division could not determine a proper carrier code, it entered a case comment indicating all known insurance carrier information. It then used "000" or "0000" as the carrier code; these codes instructed the Administration to read the case comments in an effort to determine what insurance was available.

At the time of our fieldwork in the autumn of 2003, we found 2840 children who were Medicaid beneficiaries and whose carrier codes were "000" or "0000". We reviewed insurance information for 139 of these children and found 104, or approximately 75 percent of those reviewed, may have had insurance coverage available to them through a third party.

Cause of Condition

The information in the case comments was often incomplete for clients having carrier codes of "000" and "0000"; therefore, in 1997, the Administration stopped trying to identify potential insurance carriers of clients with these codes. Eventually the Administration came to believe that these codes indicated no third party liability when, in fact, clients may have been covered by a private insurer.

After we began our audit of this area, the Department made an effort to correct the situation by creating a new code to replace the two previous codes. The new code, however, is used only for new cases, which the Administration has agreed to investigate for other insurance. There are no plans to review previous cases already in the system.

Effect of Condition

Current clients in the system under the old coding may be receiving both Medicaid and private insurance. In addition, medical and dental costs have been erroneously paid by the Medicaid program since 1997 for clients with other existing insurance. As a result of our review, we found $93,333 in costs paid by Medicaid for 104 clients. These costs should have been paid by private insurers. Approximately half of this amount, or $46,667, was paid with federal funds; state funds were used for the other half. The entire amount is included in the overall Program disclaimer.

Recommendations

We recommend the Department:

- Determine the correct insurance status of all clients with carrier codes of "000" and "0000".
- Collect from third parties any amounts erroneously paid by the Medicaid program.

Department's Response

The department concurs with this finding.

The Medical Assistance Coordination of Benefits (COB) Section reviewed all cases of carrier code "000" or "0000" as supplied by the Division of Child Support (DCS). These cases were of the following types: Medicaid, Temporary Assistance for Needy Families (TANF), Foster Care and those indicating they were not eligible for Medical Assistance. The Medicaid Management Information System (MMIS) and the DCS Support Enforcement Management System (SEMS) were updated with consistent information. Any liable third parties, who were not previously billed, were billed through the normal MMIS billing process. To prevent future discrepancies, carrier code 0000 has been eliminated. These 0000 claims will now be posted with a ZZ00. The purpose of this new code is to raise the visibility of the code above that of a miscellaneous category and to alert the COB staff of possible third-party coverage. Both organizations will review the efficiency of this coding system after one year.

In addition, the DCS and the COB Section have been participating in a study to increase the identification of liable third parties for health insurance for the past two years. The study is evaluating whether it is more effective to establish a centralized unit within the Division of Child Support or to contract with one or two vendors to increase and correctly identify health insurance liability.

Auditor's Concluding Remarks

We appreciate the Department's efforts to resolve the issues identified in the finding. We will review the controls that the Department has instituted during our next audit.

Applicable Laws and Regulations

Title 42 Code of Federal Regulations Section 433.137 states:

State plan requirements:

(a) A State plan must provide that the requirements of . . . Sec. 433.138 and 433.139 are met for identifying third parties liable for payment of services under the plan and for payment of claims involving third parties.

(b) A State plan must provide that—

(1) The requirements of . . . 433.145 through 433.148 are met for assignment of rights to benefits, cooperation with the agency in obtaining medical support or payments, and cooperation in identifying and providing information to assist the State in pursuing any liable third parties; and

(2) The requirements of . . . 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collections.

(c) The requirements of paragraph (b)(1) of this section relating to assignment of rights to benefits and cooperation in obtaining medical support or payments and paragraph (b)(2) of this section are effective for medical assistance furnished on or after October 1, 1984. The requirements of paragraph (b)(1) of this section relating to cooperation in identifying and providing information to assist the State in pursuing liable third parties are effective for medical assistance furnished on or after July 1, 1986.

Section 433.138 states:

Identifying liable third parties.

(a) Basic provisions. The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

The Office of Management and Budget's *A-133 Compliance Supplement* for Child Support Enforcement (CFDA 93.563), Section N.3 states:

The State IV-D agency must attempt to secure medical support information, and establish and enforce medical support obligations for all individuals eligible for services under 45 CFR section 302.33. Specifically, the State IV-D agency must determine whether the custodial parent and child have satisfactory health insurance other than Medicaid . . . .

The agency shall inform the Medicaid agency when a new or modified order for child support includes medical support . . . .

04-20 The Department of Social and Health Services, Medical Assistance Administration has not established sufficient internal controls to ensure that rates paid to its Healthy Options managed care providers are based on accurate data.

Background

Managed care providers receive a uniform, pre-determined, per-patient monthly rate regardless of the number of times they see a client that month and regardless of the services provided, as long as the services are covered under the plan. Although these providers are not paid based on the types of procedures, they still must report to the Administration the types of procedures they have performed. This data is to include demographic, diagnostic, and geographic information, as well as actual costs on a summary level.

The Administration contracts with an actuary to analyze the data from the managed care providers and to predict the cost of care for the next year. This actuary is responsible for the accuracy of the computations. From this information, the Administration determines a rate for each Healthy Options managed care plan. In general, the plans including sicker people will receive higher rates and the plans including healthier people will be given lower rates. Before assigning these rates, the Administration is to compare them to fee-for-service costs to ensure the managed care rates are not higher.

For the past few years, the federal grantor has considered up-coding to be a significant, common risk in managed care plans. Up-coding occurs when a provider reports a higher level of service than what is actually provided. This gives the impression that the provider is treating sicker people than they really are. Up-coding results in future rates being set higher than they would be if services were reported accurately.

In our 2003 audit, we reviewed the Administration's controls to determine if procedures were in place to ensure that only accurate data was being used to determine the rates for its Healthy Options managed care program. We found the following weaknesses:

- The Administration generally did not review its fee-for-service data for reliability and accuracy before passing it on to the actuary. The validity of this data is crucial because it helps to determine what managed care providers will be paid the following year.

- Information comparing the fee-for-service costs to the Healthy Options Managed Care costs was not easily or readily obtainable for analysis. The Administration was unable to provide this data for our review during our audit.

- Although fraud detection, enforcement, and prevention procedures were being developed and refined, only certain types of provider billings (for example, dentists and pharmacists) were being analyzed and pursued, if issues were noted.

Description and Cause of Condition

During our current audit, we attempted to determine what progress the Department had made in strengthening internal controls. We found some improvements. Fraud detection, enforcement and prevention procedures have been developed, and we found evidence that frauds are reported to the Medicaid Fraud Control Unit as required by federal regulations.

However, we found:

- The Administration still does not review its fee-for-service data for reliability and accuracy before passing it on to the actuary. It relies on automated analyses within the system to detect errors, but these analyses cannot detect all errors, particularly those that involve possible fraud, such as up-coding.

- The Administration stated it monitors in other ways to help ensure managed care providers are not up-coding, but we saw no documented evidence of this.

- The Administration does not compare fee-for-service costs to managed care costs to ensure the managed care costs are not higher. The Administration stated that it is unable to make this comparison because of the limitations of its Medical Management Information System.

- Data comparing fee-for-service costs to the managed care costs were not easily or readily obtainable for analysis. The Administration was unable to provide us with this data for our review during our audit.

- The federal grantor stated that, while it approved the Administration's current rate setting method, it still considered it to be "problematic" because it requires managed care providers to report only demographic data such as age and gender, without requiring them to report the costs of providing services. This limits the usefulness of the data. Because the regulatory requirements for actuarially sound rate development are new, the federal grantor has given Washington the flexibility to use alternate means of rate development for the next few years, with the understanding that the quality of required provider data will be improved for subsequent contracts. In the meantime, the state is required to submit semi-annual progress reports describing its efforts to improve data quality. We found no documentation supporting that the Administration submitted either of the two reports required during the past year, although the Administration stated it submitted one of them verbally.

Effect of Condition

The first four conditions increase the risk that costs will not be analyzed correctly, resulting in excessive rates being paid to managed care providers.

Failure to submit required reports may jeopardize future federal funding.

Recommendations

We recommend that the Administration:

- Adequately analyze data used in rate-setting to ensure rates are set based on accurate information.

- Follow federal requirements for semi-annual reports on its improvements to the rate-setting process.

Department's Response

The Department does not concur with this finding.

- *The Department had the same response to a similar finding in the 2003 audit. SAO continues to see an erroneous connection between current fee-for-service (FFS) costs and managed care rate setting.*

- *CMS has not required the written reports recommended by SAO and has not expressed dissatisfaction with the Department's current reporting process.*

Auditor's Concluding Remarks

The documentation that the Department is providing to the actuary is not reviewed or audited for accuracy. The Department has no controls in place to detect erroneous information. As long as this unmonitored data is given weight as a component of rate setting, the risk is present that rates will rise to a level higher than they should be.

The effects of up-coding, when perpetrated by managed care providers, may not be realized until some time in the future, if ever. Additionally, up-coding by managed care providers may not be subject to prosecution for misappropriation because the managed care plan is not receiving money or any other type of constructive gain at the time treatment is given. The return is received in subsequent years, when the up-coding data is used to set rates. Additionally, if the Department does not monitor the data for up-coding, managed care plans may perceive the risk of detection as being relatively low.

We found no follow-up monitoring to determine if providers are reporting caring for sicker patients than they actually are. For instance, one provider reported almost 1800 new born birth weights outside the norm of 2000 to 3499 grams. The Department did note an escalation of this occurrence from past encounter data submissions from this provider. However, instead of investigating why this occurred, the Department simply told the provider what it expected to see in future encounter data.

The Centers for Medicare and Medicaid has required written reports as shown in a letter to the Department which states in part:

> *" . . . Therefore, the approval of these contract amendments is subject to the following condition: the State must provide CMS with a corrective action plan which outlines the timeline, processes and steps the State intends to use to assure adequate encounter data will be available from plans contracted with both MAA and HCA for use in the rate setting process for Calendar Year 2006. That corrective action plan must be submitted to the CMS Region 10 office within 30 days of the date of this letter. In addition,* ***the State must submit progress reports, which describe the status of the implementation of the corrective action plan. Semiannual progress reports must be submitted to the CMS Region 10 office by Mar 30th and September 30th in each of the years 2004 and 2005***. (Emphasis added)

Because we were unable to obtain a copy of the corrective action plan from either the Department or the Centers, we have no evidence that this condition was met.

We reaffirm our finding that the Department has not established sufficient internal controls to ensure that rates paid to its managed care providers are based on accurate data.

Applicable Laws and Regulations

The March 2004 federal Office of Management and Budget Circular A-133 Compliance Supplement, page 4-93.778-16, states in part:

> . . . The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services . . . . The State Medicaid agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

Title 42, Code of Federal Regulations, Section 456.3, states the following regarding surveillance and utilization control:

> The Medicaid agency must implement a statewide surveillance and utilization control program that –
>
> (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
>
> (b) Assesses the quality of those services;
>
> (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part…

04-21 The Department of Social and Health Services, Medical Assistance Administration, is not complying with federal requirements to report Medicaid expenditures properly.

Background

The federal government requires states to report expenditures for medical assistance and administrative costs on a quarterly basis. This report is referred to as the CMS-64. The federal government reimburses states for a defined percentage of expenditures based on the information submitted in these reports. Line 27 of the CMS-64, Emergency Services Undocumented Aliens, is to be used to report allowable emergency expenditures for undocumented aliens.

Description of Condition

We reviewed certain types of information on the quarterly reports to determine if the Department is reporting allowable expenditures accurately. We found that the Department is not reporting any disbursements for alien emergency medical services on the CMS-64.

Between July 2003 and December 2003, the Department completed 434,888 transactions for a total of $43,193,263 in services for 12,119 undocumented aliens. However, the Department does not use Line 27 to report these expenditures. Instead, it combines payments for both allowable emergency services and unallowable non-emergency services and reports this amount in other categories of the CMS-64 as allowable expenditures.

Cause of Condition

The Department has no coding in its accounting records to differentiate emergency services from non-emergency services for undocumented aliens. All of these services are included in one accounting category.

Effect of Condition

The Department is receiving federal Medicaid funds to which it is not entitled. Because emergency and non-emergency payments for services to undocumented aliens are commingled in the accounting records, the Department cannot determine the total amount of over-payments it has received. In addition, the omission of expenditures on line 27 leads the federal grantor to believe that the state makes no expenditures for undocumented aliens and that therefore there is no risk that such expenditures are improper.

Recommendation

We recommend the Department develop account coding that would differentiate emergency from non-emergency services for undocumented aliens and report the proper allowable amount on the correct line of the CMS-64.

Department's Response

The Department does not concur with this finding.

As a result of an audit finding from SFY 2003, the Medical Assistance Administration (MAA) has reported expenditures for undocumented aliens on the CMS-64 report, effective April 1, 2004. The SFY 2004 audit should reflect all activities from July 1, 2003, through June 30, 2004. On at least two separate occasions, the MAA did advise SAO that it had established appropriate coding to report this line item effective April 2004. However, the SAO arbitrarily chose to write this finding to cover the time period from July 1, 2003, through December 31, 2003, instead.

At issue here is the SAO's interpretation of emergency services for undocumented aliens. Although the finding indicates that federal rules governing services for undocumented aliens are clear, we assert that the interpretation of these rules is complex. In response to a similar audit finding from SFY 2003, the administration has implemented a transitional policy relating to services for undocumented aliens. We provided the SAO with a copy of this transitional policy, which recognizes that all expenditures for this population are considered emergent until a permanent policy is established. The MAA has also established two workgroups that will assist in development of a permanent policy by the spring of 2005.

Auditor's Concluding Remarks

The first corrective action plan we received was dated February 2004 and indicated that the Department was unable to perform any of the necessary changes due to the modifications that needed to be made in MMIS. We substantiated that no changes were made by reviewing the CMS-64s that we had at the time.

In July, 2004, the Department informed us it was planning changes to the Alien Emergency Medical reporting process but that no work had been completed. The Department said it would inform us when the changes were made.

At each monthly update meeting with the Department from June 29 through our last meeting on September 28, we reported that this issue would be a finding. At no time during those meetings or afterward did anyone in the Department indicate that the Department had changed the reporting process or that the Department was now reporting disbursements for undocumented aliens on Line 27 in any of the CMS-64s.

On October 7, 2004, the Department provided us with its latest corrective action plan for last year's finding in this area. This plan, dated September 2004, stated:

> *The Department agrees with this element of this finding, however, it will be unable to take corrective action at this time. The ACES and MMIS systems do not currently have the capability of capturing undocumented aliens separately from documented aliens and U.S. citizens. Additionally, the MMIS does not currently have the capability of determining which services were performed as part of an emergent situation and/ or any follow-up as required under the decision from Gutierrez v. DSHS, Yakima Superior No 032017662 (2003).*

On November 17, 2004, after our fieldwork was completed, the Department indicated changes had been made to address some of the issues. However, it provided no evidence as to how these issues had suddenly been resolved, given its statement in September that the Department's systems were not capable of making the necessary distinctions. In any case, evaluating any changes that might have been made and testing any changes to controls, to the system, or to the amounts reported would have been a complex process at a time when our audit was completed. We reaffirm our finding and look forward to our review during the fiscal year 2005 audit of any changes the Department has made.

Applicable Laws and Regulations

The state of Washington's Office of Financial Management's *State Administrative and Accounting Manual,* Section 50.30.45.2, describes the reporting responsibilities of state agencies that administer or expend federal awards:

> Identify, account for, and report all expenditures of federal awards in accordance with laws, regulations, contract and grant agreements, and requirements included in this and other sections of the OFM *State Administrative and Accounting Manual***.**

Title 45, Code of Federal Regulations, Section 92.20(a), states:

> A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds.

Title 42, Code of Federal Regulations, Section 430.30(c) states:

> Expenditure reports. (1) The State must submit Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to the central office (with a copy to the regional office) not later than 30 days after the end of each quarter. (2) This report is the State's accounting of actual recorded expenditures. The disposition of Federal funds may not be reported on the basis of estimates.

The U.S. Office of Management and Budget Circular A-133*, Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states:

> The auditee shall:…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs….

04-22 The Department of Social and Health Services, Aging and Disability Services Administration, does not have sufficient internal controls to ensure it is complying with both subrecipient monitoring and matching requirements for the Medicaid Program.

Background

State agencies often distribute federal funds to other organizations that provide services needed to accomplish federal program objectives. These organizations are known as subrecipients, while the state agencies are called pass-through agencies. To help ensure that funds are spent appropriately, the federal government requires pass-through agencies to monitor the activities of subrecipients to provide reasonable assurance that they are complying with federal requirements. Monitoring requirements are contained in the federal Office of Management and Budget's Circular A-133, *Audits of States, Local Governments, and Non-profit Organizations*. Monitoring may take various forms such as reviewing reports submitted by subrecipients, regular contact with subrecipients, and performing on-site reviews of subrecipient financial and program records and operations. Factors that may affect the degree of monitoring include program complexity, amount of the award, and risks directly related to the subrecipient.

The Aging and Disability Services Administration, as a pass-through agency, has subrecipient contracts with the Area Agency on Aging in many counties. Through these contracts, skilled medical professionals provide services to Washington's elderly, either directly or in consultation with county health departments. Federal regulations permit the use of Medicaid matching funds (called Federal Financial Participation) to reimburse states for 75 percent of the costs of salaries, benefits and training of skilled medical professionals. However, federal regulations also limit these matching funds to instances where there is an employer-employee relationship between the grant recipient and the skilled professional medical personnel. During fiscal year 2004, the Administration paid the Agencies $2,521,624 for costs of skilled medical professionals and received back $1,891,218 (75 percent) in federal matching funds.

Description of Condition

We reviewed the controls related to monitoring of Medicaid funds at the Agencies. We found clear and well-written monitoring procedures. However, the monitoring actually performed is not sufficient to ensure that the Administration's reimbursements to the Agencies for its skilled medical professionals are accurately calculated. Specifically, we found:

- The Administration does not prepare written risk assessments to use as a basis for the degree of monitoring it performs.
- Agencies do not submit supporting documentation with reimbursement requests.
- The Administration actually reviews each Agency's expenditures on-site only once every three years.
- Not all areas of the contract are monitored. The review procedures do not include an evaluation of whether the skilled medical professionals listed in the budget are actually working for the Agency.

Cause of Condition

The Administration stated it has not performed more thorough reviews of the Agencies because of a lack of resources. Rather, it relies on the Agencies to follow program standards.

Effect of Condition

The Administration does not have reasonable assurance that:

- Agencies are complying with federal requirements for costs of skilled medical professionals.
- Agency claims for reimbursement of the costs of skilled medical professionals are calculated correctly and adequately supported.

- The 75 percent match it receives from federal funds for skilled medical professionals is based on accurate data. In fiscal year 2004, this match amount was $1,891,218. The total state and federal amount of $2,521,624 is included in the overall Program disclaimer.

Recommendations

We recommend the Department devote the resources necessary to ensure compliance with subrecipient monitoring and matching requirements.

Department's Response

The Department partially concurs with this finding.

The department currently follows the requirements of OMB Circular A-133 in performing its review of the agencies. Per this circular, "Monitoring activities normally occur throughout the year and may take various forms, such as reporting, site visits, and regular contact." Current resources allow for on-site monitoring every three years, although monitoring through review of financial and performance reports submitted by the subrecipient and through regular contact occurs throughout each year.

- ***The Administration does not prepare written risk assessments to use as a basis for the degree of monitoring it performs.*** *Attached are the fiscal and program assessment tools used to determine the degree of monitoring performed. The department targets the scope and frequency of its on-site monitoring based on these assessments of risk. The purpose of the Risk Assessment Tool is to assist in the process of prioritizing contract monitoring activities. The tool is used as the means to evaluate potential exposure to the chance of harm or loss that could arise from an activity or service. The column on the left lists actual programs/services, while the row across the top lists the areas to be considered for each program/service. The tool can be modified to evaluate as many areas as needed. Each area is considered for each program/service and whenever there is a perceived issue an "X" is placed in the appropriate box. In the end, each "X" is tallied in the far right column. The programs/services with the highest totals are then to be considered as priority areas for future contract monitoring activities and technical assistance focus. Interventions are targeted to specific risk factors in each Area Agency on Aging.*

- ***Agencies do not submit supporting documentation with reimbursement requests.*** *While the Area Agency on Aging (AAA) is not required to send in documentation with their reimbursement requests, we feel there are controls in place, as follows:*

    1. *The AAAs submit detailed budget documents, including a staff listing of all Registered Nurses, prior to contract approval for these costs. Often, the negotiation of these budgets involves many discussions between the AAA and State Unit on Aging (SUA) regarding the make up of all the costs of the AAA. Since July 1, 2004, subrecipients have been required to submit quarterly reports of filled and vacant positions.*
    2. *Minimum nursing-to-client ratios are established as a requirement of the subrecipient contracts.*
    3. *Reports of nursing services, including number of clients served and number of contacts, are provided on a monthly basis and compared against historical performance levels.*
    4. *All AAA billings are reviewed against the budget documents monthly by the fiscal staff and are reviewed and approved by the State Unit on Aging liaison, who has a working knowledge of the AAA staff and services being provided.*
    5. *The Budgeting, Accounting and Reporting System (BARS) manual and the Long Term Care Manual dictate the standards for the Nursing Services program and the AAA contract stipulates that the AAA must follow these requirements.*
    6. *The Home and Community Services nursing services manager frequently meets with local office nursing staff to provide training and consultation regarding program performance.*
    7. *Subrecipients are required to have periodic independent audits and the results are submitted to the Aging and Disability Services Administration (ADSA) for review.*

- ***The Administration actually reviews each Agency's expenditures on-site only once every three years.*** *While fiscal staff only go on-site every three years, we believe the other processes listed above act as additional monitoring of the contracts and payments, as required in A-133. This circular states that monitoring activities normally occur throughout the year and may take various forms. The attached risk assessment tools guide decisions regarding on-site monitoring needs.*

- ***Not all areas of the contract are monitored. The review procedures do not include an evaluation of whether the skilled medical professionals listed in the budget are actually working for the Agency.*** *Because of the other controls that are in place, this area of expenditure is considered to be extremely low-risk. Factors such as program complexity, percentage passed through, and amount of awards may affect the nature, timing, and extent of during-the-award monitoring. The Nursing Services program is only five percent of the total pass-through expenditures to these contractors. In each of the past five years the Home and Community Services Quality Assurance Unit or the State Unit on Aging has completed program monitoring, which included review of the work performed by the nurses who work for the Area Agencies on Aging. These reviews include detailed analysis of program performance requirements. For example, in 2002 this unit audited three percent of the Area Agencies on Aging client caseload, and in those cases where a case manager had referred their client to the agency nursing staff, we did monitor to determine that the nurse followed up on this referral within an appropriate time frame. We evaluated what action they took and if it was sufficient to address the issue identified.*

  Home and Community Services Quality Assurance unit is currently in another audit cycle. We are reviewing four percent of the Area Agencies on Aging caseload where we are continuing to monitor that case managers are referring to the nurses on staff and that the nurse is responding appropriately. Performance results on quality assurance measures are routinely reported to management staff at ADSA and the AAA for follow-up. With the control measures listed above, there is virtually no chance the medical professionals in the budget are not actually working.

- ***We recommend the Department devote the resources necessary to ensure compliance with subrecipient monitoring and matching requirements.*** *If the fiscal and program assessment tools identify a need for enhanced monitoring, the Administration will request additional resources in the future.*

Auditor's Concluding Remarks

We appreciate the Department's efforts in resolving some of the issues in the finding.

In response to our inquiries made during the audit, the Department did not provide us with information on any of the compensating controls or assessment tools it now lists in its response. In addition, the assessment tools now provided are blank, with no indication they were used during the fiscal year we audited.

With respect to the compensating controls:

- Many do not address the issues identified in the finding. For instance, some of the controls on the assessment tools appear to be related to performance standards, rather than to fiscal issues.

- Those controls that do address fiscal issues would not ensure that the skilled medical professionals the Agencies reported and the Department reimbursed had an employee-employer relationship with the Agencies. For example, establishing minimums for nurse-client ratios as a contractual obligation does not ensure that this requirement was met.

- Agency reports, although good tools, are inadequate on their own. Without adequate on-site monitoring, the Department has no assurance that contract provisions are being met.

- Independent audits performed of the Agencies do not guarantee that all aspects of a program are reviewed.

The Department depicts its payments to the Agencies for its skilled medical professionals as immaterial by presenting them as a nominal percentage of total expenditures. However, $2,521,621 in services for skilled medical professionals was spent in fiscal year 2004. We reaffirm our finding that the Department should reevaluate and

strengthen its monitoring of the Agencies to ensure they are following federal requirements and to ensure its own compliance with federal requirements.

Applicable Laws and Regulations

The United States Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-profit Organizations,* Section .400(d) states, in part, that a pass-through entity shall perform the following:

> 3. Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements . . . .

The Code of Federal Regulations (CFR) describes at Title 42, Section 432.50 the conditions under which federal financial participation (FFP) can be claimed in this case:

> **FFP: Staffing and training costs.**
>
> (a) Availability of FFP. FFP is available in expenditures for salary or other compensation, fringe benefits, travel, per diem, and training, at rates determined on the basis of the individual's position, as specified in paragraph (b) of this section.
>
> (b) Rates of FFP.
>
> (1) For skilled professional medical personnel and directly supporting staff of the Medicaid agency or of other public agencies (as defined in Sec. 432.2), the rate is 75 percent . . . .
>
> (d) Other limitations for FFP rate for skilled professional medical personnel and directly supporting staff—
>
> (1) Medicaid agency personnel and staff. The rate of 75 percent FFP is available for skilled professional medical personnel and directly supporting staff of the Medicaid agency if the following criteria, as applicable, are met:
>
> (i) The expenditures are for activities that are directly related to the administration of the Medicaid program, and as such do not include expenditures for medical assistance . . . .
>
> (iv) A State-documented employer-employee relationship exists between the Medicaid agency and the skilled professional medical personnel . . . .
>
> (2) Staff of other public agencies. The rate of 75 percent FFP is available for staff of other public agencies if the requirements specified in paragraph (d)(1) of this section are met and the public agency has a written agreement with the Medicaid agency to verify that these requirements are met.

04-23 The Department of Social and Health Services, Economic Services Administration, should improve compliance with eligibility requirements for the Temporary Assistance for Needy Families Program.

Background

The Department of Social and Health Services, Economic Services Administration, administers the federal Temporary Assistance for Needy Families program (CFDA 93.558). Federal regulations require each state to maintain a certain amount of state-funded expenditures each year or face financial penalties. For assistance payments to clients, the Program spent $137,463,116 in federal funds and $143,727,390 in state funds during fiscal year 2004.

The program is designed to provide time-limited assistance to needy families with children and to promote job preparation and work opportunities for the parents. As long as minimum requirements are met, states have flexibility in designing programs and determining eligibility requirements and may use grant funds to provide cash or non-cash assistance. To be eligible under federal requirements, a family generally includes a child under 18 living with the parent(s); in addition, the family must qualify as needy under a state's criteria. The state also has specified that, with certain exceptions, applicants must provide Social Security numbers in order to receive Program benefits.

During the fiscal year 2002 and 2003 audits, we identified weaknesses related to compliance with eligibility requirements and reported them in the Statewide Accountability Report and in the State of Washington Single Audit Report.

Description of Condition

During our current audit of the Program, we selected clients who received benefits from July 1, 2003, through June 30, 2004. We again found instances of noncompliance with eligibility requirements in the following areas:

a. We reviewed the validity of Social Security numbers for active Program recipients and found six recipients who had Social Security numbers that were not issued by the Social Security Administration and were therefore invalid. Total Program payments to these ineligible recipients amounted to an estimated $12,850. Including prior year payments, the total is an estimated $33,001.

b. We also reviewed the validity of Social Security numbers of active recipients who provided the Department with Social Security numbers of persons reported to the Social Security Administration as deceased. We found eight such instances. Total Program payments to these ineligible recipients amounted to an estimated $18,253. Including prior year payments, the total is an estimated $39,985.

c. We also found nine instances in which invalid numbers appeared to have been entered because of Departmental error, rather than because of inaccurate information provided by clients. Program payments in these instances totaled an estimated $8,257. Including prior year payments, the total is an estimated $16,812.

d. During our review we found one recipient who received benefits from two different Departmental assistance units for four months due to a child custody arrangement. The unallowable part of these double payments totaled $1,480.

Cause of Condition

The Department identified several reasons that may have caused these conditions, including worker error and a client's use of a first or surname at the Department that was different from the one the client submitted to the Social Security Administration.

Effect of Condition

Clients who may not be eligible are receiving both state and federal benefits. In addition, failure to use all resources available for verifying eligibility could leave the Department susceptible to fraud and could lead to a reduction in federal grant funds. We estimate that, for the $40,840 identified above, $19,965 was charged to the federal program and $20,875 was charged to state funds. Federal regulations require the auditor to question and report unallowable costs greater than $10,000. Accordingly, we are questioning these amounts.

Recommendation

We recommend the Department:

a. Periodically compare information provided by recipients with applicable records maintained with other state agencies and investigate any discrepancies.

b. Require employees to follow state regulations regarding Social Security numbers and investigate and resolve invalid numbers.

c. Require employees to follow state regulations regarding sharing child custody to prevent any double payments.

Department's Response

The Department concurs with the finding. The Economic Services Administration (ESA) has recently made changes to the electronic interface between the Department and the Social Security Administration (SSA) that will provide a broader search of the SSA databases and provide more opportunities to match the Social Security Numbers (SSN) sent from the Department. Additionally, changes planned to the current State On-line Query interface with SSA will greatly enhance the ability to identify accurate SSNs. Before ESA can implement the proposed changes, the SSA must approve the changes. Assuming SSA approval of these changes, the Department estimates the implementation by December, 2005.

On-going staff training to address this issue and future system enhancements will be provided.

Auditor's Concluding Remarks

We appreciate the Department's efforts in addressing this finding. We will review the Department's progress during our next regular audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states in part:

> The auditee shall . . .
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs . . . .

Subpart A, Section 105 of the Circular states in part:

> . . . a questioned cost means a cost that is questioned by the auditor because of a finding:
>
> (1) Which resulted from a violation or possible violation of a provision of law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the use of Federal funds, including funds used to match Federal funds ;

(2) Where the costs, at the time of the audit, are not supported by adequate documentation; or

(3) Where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.

Subpart E, Section 510 of the Circular states includes the following as audit findings the auditor shall report in a schedule of findings and questioned costs:

(a) (3) Known questioned costs which are greater than $10,000 for a type of compliance requirement for a major program.

Washington Administrative Code 388-476-0005 states in part:

(1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security Number (SSN) or numbers if more than one has been issued.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;
(b) Provide proof that the SSN has been applied for; and
(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

Washington Administrative Code 388-454-0005 states in part:

(2) If a child lives with more than one relative or parent because the relatives share custody of the child:

a) We include the child in the assistance unit (AU) of the parent or relative that the child lives with for the majority of the time; or

b) If relatives share physical custody of the child in equal amounts, we include the child in the AU of the parent or relative that first applies for assistance for the child.

04-24 The Department of Employment Security paid at least $142,847 in unemployment insurance benefits to claimants who were not eligible. The Department also overpaid and underpaid eligible claimants by $18,873 and $5,150, respectively. In addition, we estimated that payments totaling more than $185,000 were made to claimants during their first week of unemployment, which is prohibited by state law.

Background

The Department pays more than $1.7 billion a year in benefits to unemployed workers through the Unemployment Insurance program (CFDA 17.225).

Description of Condition

During our audit, we reviewed unemployment insurance benefit payments and found that at least $142,847 in benefits was paid to claimants who were not eligible for benefits due to invalid Social Security numbers or because they already were receiving benefits for an on-the-job injury.

We found:

- Thirty-eight claimants received unemployment and workers' compensation benefits for the same time period. This is a violation of state law. These payments totaled $125,566.

- Eight claimants used Social Security numbers of deceased individuals to receive benefits. These claimants are not eligible according to the Department's benefit eligibility policies. These claimants were paid a total of $16,912. Seven of the eight claimants were reported to the Department by our Office in February 2004 as part of last year's audit. We verified that the Department discontinued making payments to these individuals after we noted the condition.

- One claimant used an invalid Social Security number to receive benefits. This claimant is not eligible according to the Department's benefit eligibility policies. Payments made to this individual totaled $369.

In addition to the overpayments described above, we found that the Department paid several claimants during their first week of unemployment, which is prohibited by state law. When we examined this area, we produced a report that compared the weeks of unemployment to the benefit payment weeks and found 1,532 matches. We selected 60 of the 1,532 claimants and found 18 (30 percent) were paid during the first week of unemployment. Since the amount paid totaled $462,616 over a nine-month period, we estimate that the amount would have been approximately $616,821 for a 12-month period. Therefore, we estimate that $185,046 (30 percent of $616,812) was paid to claimants during their first week of unemployment.

These issues were reported to the Department as a finding during last year's audit.

Our review also revealed 9 claimants whose benefits were not properly reduced by their retirement pension benefits, as required by state law. Six claimants were overpaid by $18,873 and three claimants were underpaid by $5,150.

We found significant decreases in overpayments of unemployment benefits since our last audit in the following areas:

- Claimants that received benefits while incarcerated decreased from 15 claimants to zero claimants.

- Duplicate benefit payments decreased from 13 to zero.

Cause of Condition

The Department performs a cross-match of claimants' Social Security numbers with data from the Social Security Administration, but does not have procedures to identify deceased claimants and claimants receiving industrial insurance benefits.

The General Unemployment Insurance Development Effort system is the Department's unemployment insurance benefit payment system. An error in the system caused several claimants to be paid for their first week of unemployment, which is prohibited by law. This error has caused claimant overpayments since the system went on line in 1997. Management has been aware of this error since 1997, but considers the overpayments administrative errors and has not billed claimants for the overpayments.

We also found human errors in the calculation of the reductions to unemployment insurance benefit due to pension benefits. We also noted the Department does not consistently obtain direct verification with the retirement plan administrator as required by Washington Administrative Code. Instead, it relies on the claimant to provide information related to the share of the employee contribution to the retirement plan.

During the 2003 legislative session, state law was changed to require that interest penalties collected by the Department from delinquent claimants be used first ". . . to fully fund either social security number cross-match audits or other more effective activities that ensure that individuals are entitled to all amounts of benefits that they are paid . . ." For the 2003-2005 biennium, the Legislature appropriated $6.7 million from this fund to community and technical colleges, which made this money unavailable for the Department to fully correct the issues identified during our last audit.

Effect of Condition

Without adequate internal controls over the disbursement of unemployment insurance benefits, the Department cannot ensure that benefits are being paid to eligible claimants for the correct amounts.

Recommendation

We recommend the Department:

- Improve its effort to cross-match its Social Security data with data from the Social Security Administration to identify claimants with invalid Social Security numbers and claimants using Social Security numbers belonging to deceased individuals.

- Consider sharing or obtaining data from the Department of Labor and Industries to match Social Security numbers on claimants receiving industrial insurance benefits.

- Improve the benefit payment system to prohibit payments during the claimant's first week of employment.

- Establish and follow procedures to ensure that all pension benefit reductions are accurately calculated and that the Department obtains written certifications from the administrator of the pension plan.

Department's Response

We appreciate the work performed by the State Auditor's Office on our Unemployment Insurance (UI) benefit payment processes. As usual, the audit has identified things that we can do to improve the UI program. Our agency currently performs extensive cross matches, data mining and other fraud prevention and detection efforts for the UI program. Our Office of Special Investigations and their fraud prevention and detection efforts continue to be recognized as a leader in the nation, by the USDOL and other states.

In response to the issues identified by the auditor the agency has taken the following actions:

Payments totaling an estimated $185,000 were made to claimants during the first week of unemployment, which is prohibited by state law.

This finding is based on SAO's projections of the results of sampled transactions. We are uncomfortable with the validity of a projection because of the numerous changes that occurred in the UI program during the time of the audit. During that time, we triggered off of Extended Benefits, the Temporary Emergency Unemployment Compensation program ended and we implemented numerous changes to the UI program as mandated by Second Engrossed Senate Bill (SESB) 6097.

GUIDE staff have not yet implemented program changes to prevent the waiting week from moving to the first compensable week of the claim when the first weeks of the claim are paid out of order and a claim recalculation occurs. Since mid July 2003, the primary focus has been implementation of the far-reaching effects of UI legislative revisions. These changes required the use of the majority of GUIDE resources as well as common programming code. It was not possible to work both of these high priority items at the same time. The final implementation of benefit related legislative revisions are scheduled for the end of this year. Attention can then be refocused on the waiting week issue. Preliminary system requirements/design for this effort was completed in June 2004.

Eight claimants received benefits using the Social Security Numbers (SSN) of deceased individuals. The claimants were paid $16,912. In addition, one claimant received benefits using an invalid Social Security Number. The claimant was paid $369.

Eight of the nine cases of claimants using the SSN of a deceased person or an invalid SSN were brought to our attention during last year's audit. These eight were adjudicated prior to the exit interview with the State Auditor's Office in February 2004. We do not believe that these claims should be included again this year, because they were addressed during last year's audit. Also, the Department is currently in the process of establishing an overpayment for the remaining claimant who used the Social Security Number of a deceased individual.

Thirty-eight claimants received both unemployment and workers compensation benefits for the same time period. This is a violation of state law. These payments totaled $125,566.

We agree with the audit finding concerning 38 claimants receiving both unemployment and workers compensation benefits for similar time periods. The UI Division has submitted a service request to implement a weekly Unemployment Insurance/Labor and Industries (L&I) crossmatch designed to immediately identify those claimants who have filed for and are receiving both UI and workers compensation benefits simultaneously. The Total Temporary Disability (TTD) unit will work the GUIDE-generated report and establish procedures to severely limit both overpayment and fraud activity. The service request will be given top priority once the work related to implementation of SESB 6097 is completed, so we anticipate the weekly crossmatch to begin soon. We also intend to work with the Department of Labor and Industries to improve coordination and communication when back pay awards of workers compensation benefits occur.

Nine claimants did not have their benefits properly reduced by their retirement pensions. Six were overpaid a total of $18,874 and three were underpaid a total of $5,251.

The audit report lists issues with nine pensions - six overpayments and three underpayments. UI Policy staff carefully researched each claim. All cases of over and under payment are being forwarded to the appropriate TeleCenter for action with the exception of cases where there was nondisclosure of pensions by claimants. Those files are being forwarded to the Office of Special Investigations for potential fraud determinations. Also, training on pensions and pension deductions will be reviewed and amended as needed to insure that staff are properly calculating and deducting pensions.

Auditor's Concluding Remarks

We appreciate the Department's efforts in addressing this finding.

The method we used to estimate the total payments made to claimants during the first week of unemployment is an accepted and proven audit practice. Therefore, we reaffirm our estimate of $185,046.

The Department is correct that eight overpayments to individuals using Social Security numbers of deceased individuals or invalid Social Security numbers were identified and reported to the Department during the prior audit. However, overpayments continued to be made to these claimants during this year's audit period. Federal regulations require our Office to report overpayments of this magnitude.

We will review the agency's progress during our next regular audit.

Applicable Laws and Regulations

RCW 50.04.323 (1) states in part:

> The amount of benefits payable to an individual for any week which begins . . . in a period with respect to which such individual is receiving a governmental or other pension, retirement or retired pay, annuity, or any other similar periodic payment which is based on the previous work of such individual shall be reduced (but not below zero) by an amount equal to the amount of such pension, retirement or retired pay, annuity, or other payment, which is reasonably attributable to such week.

RCW 50.04.323 (1)(b) states in part:

> The amount of such a reduction shall take into account contributions made by the individual for the pension, retirement or retired pay, annuity, or other similar periodic payment, in accordance with regulations prescribed by the commissioner.

RCW 50.20.010 (1) states in part:

> An unemployed individual shall be eligible to receive waiting period credit or benefits with respect to any week in his or her eligibility period only if the commissioner finds that: . . . (c) He or she is able to work, and is available for work in any trade, occupation, profession, or business for which he or she is reasonably fitted [and] (d) He or she has been unemployed for a waiting period of one week.

RCW 50.20.085 states:

> An individual is disqualified from benefits with respect to any day or days for which he or she is receiving, has received, or will receive compensation under RCW 51.32.060 or 51.32.090.

RCW 51.32.060 is the state law providing compensation for permanent total disability in the case of an industrial accident, which is referred to as workers' compensation pensions.

RCW 51.32.090 is the state law providing compensation for temporary total disability in the case of an industrial accident, which is referred to as workers' compensation time loss.

WAC 192-110-005 (3) states in part:

> The first week you are eligible for benefits is your waiting week. You will not be paid for this week . . .

WAC 192-16-030 states in part:

> The deductible pension amount shall be determined as of the last pay period in the individual's base year for which contributions were made.

Unemployment Insurance Procedures Manual, Section 5100.00, General Information -- Initial Claim, states in part:

> Without a social security number (SSN), a claim for unemployment insurance cannot be completed. A correct SSN is essential to establish an unemployment insurance claim. During the initial claim process, verification of identity will occur . . . SSNs that have never been issued, belong to another individual or belong to a deceased person will be flagged . . . .

Section 20.20.20.a of the Office of Financial Management's State Administrative and Accounting Manual states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

04-25 The Department of Social and Health Services, Division of Child Care and Early Learning, does not have adequate internal controls over support for payments made to child care providers.

Background

The Department of Social and Health Services administers child care programs that pay child care centers and licensed family home child care providers for child care services for eligible families. The Department either pays the providers directly or pays clients directly, with the expectation that the clients will then use the funds for child care services. The Department has assigned responsibility for the Program to the Economic Services Administration, Division of Child Care and Early Learning. Payments are made from various funding sources, including several federal programs.

During our fiscal year 2003 audit, we found that the Division did not require adequate supporting documentation in the form of attendance records from all of it providers. The Division requires that child care centers have the parent or custodian sign the child in and out of care and note the time of arrival and departure. This is not required for family home child care providers. In addition, the attendance records that were available were not always adequate.

Program payments to vendors and clients are made from both state and federal funds. During fiscal year 2004, total payments for the Division of Child Care and Early Learning program were approximately $255 million.

Description of Condition

We found the Division continues to allow providers to use inadequate alternative records as support for payments issued. These records do not require the parent or custodian to sign the child in and out of care each day and note the time the child arrived and departed. Therefore, this issue has not been resolved. In addition, the Division did not monitor its providers to determine if they had any attendance records to support their billings.

The Division stated that in October 2004, the Department began requiring that children be signed in and out of the family home facilities and that adequate attendance records are maintained. We will review this during the fiscal year 2005 audit and make a determination at that time as to whether these controls were appropriately implemented and are now adequate.

Cause of Condition

The Division had been working on establishing the attendance record requirement for several years and only recently was able to put it in place. The Division stopped any on-site monitoring this year because of reduced staff.

Effect of Condition

The Department cannot be assured it is paying child care providers only for the hours that children are actually in care. The Department has established total overpayments to child care providers in the amount of approximately $2.2 million. We question these overpayments, which were made from various funding sources, including several federal programs.

Recommendation

We recommend the Department:

- Require all child care providers to use a standard attendance record issued by the Department.
- Require all child care providers to have the parent or custodian of each child sign the standard attendance record when the child arrives and departs from care, noting the arrival and departure times.
- Monitor providers to ensure that attendance records support the payments made.

Department's Response

The Department partially concurs with this finding.

The Division of Child Care and Early Learning (DCCEL) concurs that there are not adequate internal controls over support for payments made to licensed family home providers. DCCEL is not currently funded to conduct comprehensive subsidy monitoring activities. However, DCCEL is coordinating quality assurance activities with the Community Services Division to ensure supervisory reviews of child care subsidy cases; Payment Review Program to identify and collect overpayments through the use of algorithms; and Division of Fraud Investigations to ensure in-home child care is occurring in the child's home. DCCEL has also coordinated quality assurance activities with the Division of Employment and Assistance Programs to monitor subsidy payments to a targeted group of family child care homes and the Operations Review and Consultation to monitor subsidy payments to a targeted child care centers.

We believe the Department will do a better job if the e-Child Care program is implemented. Currently, the Social Service Payment System allows duplicate authorizations, the age rate categories and age of the child are not included in the payment calculation, and there is no reconciliation between the original authorization and attendance detail. The proposed e-Child Care program is designed to resolve these problems, and many others, through the use of a newly designed electronic tracking and case management system.

The Department questions the accuracy of the $2.2 million in overpayments mentioned in this report. This amount listed may include overpayments from former years or overpayments that have been established but not yet paid by the end of the last fiscal year.

On October 1, 2004, the Washington Administrative Code was changed to require parents to sign their children in and out of care. DCCEL developed a standard form that can be used for attendance keeping and the sign-in and – out process. However, we have not made the use of this particular form mandatory. Our position is that the key elements must be in place on any attendance form used. That includes the date, child's name, time in, time out, and parent's signature.

Auditor's Concluding Remarks

We reaffirm our finding. During fiscal year 2004 the Division continued to allow providers to use inadequate alternative records as support for payments. In addition, the Division did not monitor to ensure that available documents supported payments made to providers. We appreciate that DCCEL is working to develop a standard form and restate our recommendation that this form be required.

The Department provided us with a report that established its total overpayments to child care providers in the amount of $2.2 million as of June 30, 2004. We agree this may include amounts established in previous years. However, the Department was unable to separate the portion of that amount that related only to fiscal year 2004.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C, Basic Guidelines, states in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:

   j. Be adequately documented.

The same section of the circular states in part:

> 4.a. Applicable credits refer to those receipts or reductions of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are:…rebates or allowances, recoveries or indemnities on losses,...charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

04-26 The Department of Social and Health Services, Economic Services Administration wrote-off child care overpayments to providers without adequate support and inappropriately decreased amounts owed to the Department by child care providers.

Background

The Department of Social and Health Services administers the federally funded Seasonal Child Care Program, which pays day-care centers and in-home providers for child care services for eligible families. The Department has assigned responsibility for the Program to the Economic Services Administration, Division of Child Care and Early Learning. Program payments are made through the Social Services Payment System from federal funds in the Child Care Development Fund-Discretionary.

During fiscal year 2003, we reviewed the Department's Division of Fraud Investigations' findings related to the Mattawa child care investigation. Based on the work we performed and review of the Division's findings, we issued special investigation report, No. 6370, on May 28, 2003. In this report we communicated that some providers of family child care homes in Mattawa, Washington, made significant misstatements about their identities and/or failed to supply adequate attendance documentation to support billings submitted to the Department.

At that time, we recommended the Department:

- Seek recovery of improper payments from the providers who gave false information and forward these cases to the Grant County Prosecuting Attorney's Office for any further action deemed appropriate under the circumstances. Any compromise or settlement of this claim must be approved in writing by the Attorney General and the State Auditor, as directed in RCW 43.09.330. These payments totaled $839,071.

- Seek recovery of all child care payments from providers who did not supply adequate supporting attendance records.

- Work with the U.S. Department of Health and Human Services to determine the amount of questioned costs to be returned by the Department to the federal grantor.

During the fiscal year 2004 audit, our objective was to determine the status of the Department's recovery process.

Description of Condition

State regulations require providers to maintain support for billings on the premises. The Division of Fraud Investigations served subpoenas on all of the Mattawa providers more than two years ago, at which time all attendance records were to be turned over to the investigators. The Division found some instances of apparent identity theft and significant instances of inadequate documentation to support billings Seven cases were closed administratively without further action. During our audit, more than two years after the Division began its investigation, there were still eight cases which the Department had not analyzed for the establishment of overpayments. For the others, the Department used a variety of procedures when it began overpayment proceedings.

Overpayment Reductions

Division of Child Care and Early Learning

Some instances of inadequate documentation were referred directly to the Division of Child Care and Early Learning for resolution. The Division sent letters to the providers explaining that the attendance records provided by them as a result of the subpoenas were incomplete and that providers could send in additional proof of the children's attendance. The Division provided detailed information regarding the additional information needed to clear the overpayments. Each letter specifically stated all three of the following items for the unsupported payments:

- The month and the year of the provider's invoice.

- The children's names included on the invoice.

- The amount the Department may have overpaid.

Instead of relying on the attendance records obtained from the subpoenas, the Division provided a complete list of all information a provider would need to create an attendance record to "support" the payments the Division had made. The Division sent these letters long after the subpoenas were served. It then accepted as adequate proof of attendance any records the providers sent as a result of those letters.

Attendance records provided long after the subpoena was issued may not be originals and do not provide adequate evidence that a service was provided.

We noted one case in which a provider originally owed $17,334; after additional attendance records were received, the amount owed to the Department was reduced by $16,714 to $620.

Moses Lake Community Service Office

The Division of Fraud Investigations sent some cases directly to the Moses Lake Community Service Office to determine the amount of overpayments owed to the Department. Because attendance records are the supporting documents confirming whether a service was performed, the Office compared the payments the providers received with the attendance records that were obtained from the subpoenas.

As a result of this lengthy process, the Office determined that $384,449 was owed to the Department from 13 of the cases. However, the Division of Child Care and Early Learning then performed its own procedures for eight of the providers as described above, and asked providers for additional records. The Division's reassessment based on the additional records received lowered the total overpayment for these cases to $59,776, a reduction of $324,673.

We reviewed notes for one of these cases and found the Department told the provider that, based on her additional documentation, her overpayment had been decreased to $1,707.50 from the original $34,407.56 assessment made at the Community Services Office. The provider then stated that she would review the adjusted overpayment to see if she had paper work for the remaining children on the revised overpayment. This example demonstrates the ease with which a provider could create fictitious attendance records or alter records.

Overpayment Write-offs

The Division of Fraud Investigations originally determined that the Department paid $839,071 to 12 providers who supplied identity misstatements. The Office of Financial Recovery wrote off the debt for two of the providers in the total amount of $371,174 because the Department was unable to locate them.

Overpayment Collections

The Department has collected a total of $2,618 from five providers.

Cause of Condition

The Division accepted unreliable attendance documentation that may have been produced long after-the-fact because it believes that care was provided to the children. Established overpayments have not been collected in part because the Department continues to request documents and reduce overpayment amounts.

Effect of Condition

The Department has reduced the amount of overpayments to date by $904,947. Of the remaining amount, it has collected only $2,618. The table below demonstrates the status by the end of our audit:

Analysis by:	Original Amount	After Revisions	Payments Made
Fraud Investigations	$ 839,554	$ 371,174	$ 483
Community Service Office	384,449	59,776	650
Child Care and Early Learning	86,991	55,228	1,485
Total	$1,310,994	$ 486,178	$ 2,618

Recommendation

We recommend the Department:

- Seek recovery of all child care payments from providers who did not have adequate supporting attendance records at the time of the subpoenas.
- Enhance collection procedures and consider the use of collection agencies to recover overpayments.
- Transmit to prosecutors any information submitted by providers who were found by the Division of Fraud Investigations to have misstated their identities.
- Work with the U.S. Department of Health and Human Services to determine the amount of uncollectible overpayments which need to be returned by the Department to the federal grantor.

Department's Response

The Department does not concur with this finding. Economic Services Administration does not "write-off" or "inappropriately decrease" any child care overpayments. All providers who receive a Vendor Overpayment Notice have rights to due process. This includes the opportunity to provide additional information. In this situation, the Division of Child Care and Early Learning (DCCEL) gathered information to determine a more complete picture of the amount owed prior to establishing the overpayment amounts. The Department usually conducts a pre-hearing conference with a provider after the Vendor Overpayment Notice is written and the provider requests an administrative hearing. An Administrative Law Judge is also able to reduce the amount owed at the time of the hearing based on additional information. The Department seeks recovery of child care payments only when there is no documentation to support subsidy billing.

On October 1, 2004, DCCEL adopted revised Washington Administrative Code (WAC) requiring parents to sign children in and out of care on a daily basis. These attendance records are now required documentation for amounts claimed and paid to providers. Prior to October 1, 2004, any record that showed the child was in care was accepted as proof of attendance. For example, attendance records from the provider, the food program, Seasonal Child Care Contractors, and parent affidavits were all accepted as appropriate documentation.

Auditor's Concluding Remarks

State regulations (WAC 388-155-460) state, in part, that the licensee must maintain attendance records on the premises and complete them daily, including arrival and departure times. They further state that attendance records and invoices for state-paid children are to be maintained for at least five years. The Department's Division of Fraud Investigations issued subpoenas in 2002. The subpoenas required the providers to produce copies immediately of any and all children's attendance records. Attendance records that appear long after a subpoena was issued do not provide adequate evidence that a service was provided. We reaffirm our finding.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states in part:

> The auditee shall . . .
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

The Office of Financial Management's State Administrative and Accounting Manual, Section 85.54.50.b states:

> **Written procedures are to be developed and followed to ensure that past due receivables are followed up promptly and in a manner that is cost-effective for the overall collection program.** These procedures are to provide for the full range of collection procedures to be used as appropriate, including issuance of statements and dunning letters, phone and personal interviews, filing of suits and liens, referral to private collection agencies or letter services, etc. Agencies that do not have special statutory collection authority, or specialized collection operations are encouraged to use collection agencies after receivables become 90 days past due.

04-27 The Department of Social and Health Services, Division of Child Care and Early Learning, does not ensure that all recovered overpayments are credited to the appropriate funding source.

Background

The Department of Social and Health Services administers child care programs that pay child care centers and licensed family home child care providers for child care services for eligible families. The Department either pays the providers directly or pays clients directly, with the expectation that the clients will then use the funds for child care services. Program payments are made from both state and federal funds. The Department has assigned responsibility for the Program to the Economic Services Administration, Division of Child Care and Early Learning.

Child care overpayments are primarily identified by case workers during eligibility update reviews. The field offices report identified overpayments to the Department's Office of Financial Recovery. The Department has also recently started using computerized processes to identify overpayments.

Client overpayments as of June 30, 2004, were approximately $6,388,000. Overpayments identified in a current fiscal year may not be recovered until a future fiscal year.

During the fiscal year 2003 audit, we found that the Department did not ensure that all funds recovered from client overpayments were returned to the proper funding source. The Department stated that approximately $136,000 was recovered from client overpayments. However, the Department was not able to determine how much of this amount was initially paid with federal and state funds and to which funding source funds should be returned. We reported this weakness in the Statewide Accountability Report and in the State of Washington Single Audit Report. The Department did not concur with this finding and stated it codes the recovery to the original line of coding used for the expenditure. It explained that our Office did not understand the process it uses.

Description of Condition

During our fiscal year 2004 audit we found the Department still does not ensure all funds recovered from client overpayments are returned to the proper funding source.

We attempted to verify that recoveries were coded to the original line of coding used for the payment, as the Department stated. We selected a recovery and asked the Department to show us how it had been credited to the proper source of funding. The Department was not able to demonstrate that the individual recovery was recorded anywhere in its accounting records, much less in the proper funding source.

The Department stated that generic coding is used to account for the client recoveries. We tested one of the generic codes used and found that the funding source changed multiple times throughout the audit period.

As discussed earlier, last year the Department stated it received approximately $136,000 in client recoveries. This year we were told that, prior to February 2004, the Department could not identify client recoveries separately from vendor recoveries. During the last five months of the fiscal year, February 2004 through June 2004, the Department was able to make this distinction and recovered $112,000 in client overpayments. However, as with last year, the Department is still not able to determine how much of this amount collected was initially paid with federal and state funds and to which funding source funds should be returned.

Cause of Condition

The computer system used for client overpayments is inadequate for tracking the original funding sources, and the Department has not developed an alternative method of determining to which funding sources client overpayments should be returned.

Effect of Condition

The Department may not be returning recoveries of federal funds to the proper funding sources as required by federal regulations. Payments originally made with federal program funds may be returned and credited to entirely different federal programs or to state funds.

Recommendation

We recommend the Department develop an adequate method of ensuring that all funds recovered are returned to their proper sources.

Department's Response

The Department concurs with this finding. We recognize the need to improve our process and have placed additional effort in this area. The Department's Financial Services Administration is in the process of modifying the Client Receivable System to include the detailed coding structure and historical data needed to ensure that recovered client overpayments are credited to the appropriate funding source. We expect testing to begin in April 2005 with implementation by the end of June 2005.

Auditor's Concluding Remark

We appreciate the Department's prompt and thorough response and its commitment to resolving these issues.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C, Basic Guidelines, states in part:

> 4.a. Applicable credits refer to those receipts or reductions of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are . . . rebates or allowances, recoveries or indemnities on losses, . . . charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

04-28 The Department of Social and Health Services, Economic Services Administration, did not properly monitor its contract with a non-profit organization that billed for services it did not provide.

Background

The Department of Social and Health Services, Economic Services Administration's Basic Food, Education, and Outreach Program contracts with non-profit organizations to educate potential applicants about food stamps and to assist them in completing applications. The Program receives funds from the federal State Administrative Matching Grants for the Food Stamp Program (CFDA 10.561).

To bill the Department for its services, a contractor enters information about the clients it contacted in person into the Department's on-line Food Stamp Education Reporting System. The client contact data must contain, at a minimum, each client's name and Social Security number or birth date. The contract states a contractor is to bill $59 for the visit if the consultation occurred in the contractor's office or $75 if it occurred at the client's home.

Description of Condition

During our 2004 audit, the Department's Division of Fraud Investigations learned from a former employee of a non-profit organization receiving funds from this Program that the organization was billing the Department for services not provided. This organization had received federal fiscal year contracts for 2003 and 2004 of approximately $1.5 and $1.1 million, respectively.

The Division received information that the organization may have submitted excessive monthly billings when a director instructed the former employee to add names and Social Security numbers of people with whom the organization did not have face-to-face consultations.

The Division stated it served a search warrant on the non-profit organization to obtain information necessary to determine the validity of the information. Investigators inquired of 64 selected clients listed on the billings and found that 60 of them stated they never had received such consultations. Program staff members then performed their own review and found 197 of the 222 clients they contacted reported the same lack of consultation.

We reviewed the Division's and the Program's preliminary work and found there was sufficient information to merit additional work by the State Auditor's Office. We performed the review to determine the internal control weaknesses that allowed this condition to occur without detection for a long period of time and to verify the amount of the loss.

Cause of Condition

The Program did not monitor to ensure that services billed had been performed. For instance, it did not require any supporting documentation, such as documents signed by clients acknowledging that the non-profit had consulted with them about the Program.

Further, during an internal review of the contract, the Department found that agreements outside of the contract were made with the contractor. These agreements included the Department's willingness to accept consultations by telephone or postcard rather than in person. However, the Division of Fraud Investigations found clients inappropriately added to the billings by the non-profit were not contacted in any form.

Effect of Condition

The Department paid approximately $1.1 million to this non-profit for services it claimed to have provided to clients from June 2002 through September 2003, the 16-month period the Division of Fraud Investigations reviewed. Federal funds provided 50 percent of the total, with the remaining amount supplied by state and local funds.

We question the $1.1 million due to the lack of supporting documentation, the Department's inadequate monitoring, and the high rate of falsified billing records and misappropriation of public funds identified by the Division.

Recommendation

To improve its internal controls, we recommend the Program:

- Verify with clients, on a routine basis, that services have been received.

- Require contractors to provide supporting documentation for client consultations. This could include a document signed by the client and by the contractor's employee performing the consultation. At a minimum, this document should include the client's name, address, and telephone number.

- Ensure contractors follow the terms of contracts as written; if changes are required, they should be included in written amendments.

We also recommend the State Attorney General's Office and the Pierce County Prosecuting Attorney review this matter for any action deemed appropriate.

We further recommend the Department consult with the grantor, the federal Department of Agriculture, to determine the amount it may have to return to the federal government as a result of these questioned costs.

Department's Response

The Department partially concurs with the finding.

** The Economic Services Administration (ESA) does not concur with the State Auditor's Office findings that verbal agreements were made with South Sound Outreach Services (SSOS) to accept consultations by telephone or postcard under the Basic Food Education and Outreach contract. The contract specifically states "in person contacts" and meetings were held with the lead agencies (July 2002, January 2003, May 2003, and November 2003) that included discussions of the contents of the Basic Food Education and Outreach state plan and the contract. A letter was also sent to South Sound Outreach Services on March 7, 2002, emphasizing that all innovative services must have prior written authorization.*

** ESA does not concur with the State Auditor's Office questioning of the entire $1.1 million contract with SSOS for June 2002 to September 2003 for services SSOS claimed to provide to clients. The contract with SSOS included a requirement to oversee their seven other subcontractors of education and outreach services, in addition to education and outreach services SSOS provided directly to clients. The Department believes the total alleged fraudulent payment amounts were limited to $215,218 State and Federal funds paid to SSOS for services directly delivered by SSOS.*

Each subcontractor independently entered client contact information into the Basic Food Education and Outreach online reporting to the Department. No fraud or billing irregularities have been found with any of the seven other subcontractor's reporting or billing. Of the total $1.1 million in question spanning from June 2002 to September 2003, the alleged fraudulent payment amounts were limited to $215,218 State and Federal funds paid to SSOS for services directly delivered by SSOS. Of this amount $42,664 was state funding and $172,554 was federal funding provided by United States Department of Agriculture through Food and Nutrition Services. SSOS contributed $129,890 in local private matching funds for this contract period and this amount should not be included in the questioned costs.

** The Department partially concurs with the State Auditor's Office findings on inadequate monitoring of a non-profit organization under the Basic Food Education and Outreach program.*

At the time of the initial allegations in October 2003, ESA was completing a thorough review of the monthly billing invoices and back up online documentation. We acknowledge, however, that our monitoring did not contain controls capable of discovering the alleged fraud perpetrated by SSOS.

In December 2003, ESA implemented changes to internal processes to reasonably ensure that SSOS is in compliance with applicable laws, regulations, and provisions stated in the audit finding. Additionally, the Basic

Food Education and Outreach Program also implemented changes to their monitoring processes, to include random client contacts for all other contracts.

Upon receipt of information from a former SSOS employee that ESA was being billed for clients that were not being seen, ESA strengthened its payment review process for SSOS billings. ESA specifically reviewed SSOS client contacts submitted via the electronic reporting system and only approved payment for those clients who provided verbal or signed confirmation of services.

Auditor's Concluding Remarks

The Administration states it does not concur with our findings that verbal agreements were made with the non-profit organization to accept consultations by telephone or postcard under the Basic Food Education and Outreach contract. We are aware that once the Administration found these types of consultations, the practice stopped. However, these consultations were performed outside of contract terms. The Administration did not determine the number of questionable consultations, and funds paid for these types of consultations have not been recouped.

The Administration does not concur with our questioning the $1.1 million because the non-profit organization had subcontractors who also provided education and outreach services with these funds. However, our review of the weaknesses that led to the specific over-billing described in the finding showed the Department was not adequately monitoring the overall activities of the non-profit organization. As a result, we determined it necessary to question all the costs."

We appreciate the Administration's work to resolve the contract monitoring process. We look forward to reviewing this area in the fiscal year 2005 audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states in part:

> The auditee shall . . .
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs . . .

Subpart A, Section .105 of Circular A-133 further states in part:

> Questioned cost means a cost that is questioned by the auditor because of an audit finding . . . (2) Where the costs, at the time of the audit, are not supported by adequate documentation . . .

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments,* Attachment C, states in part:

> 1. . . . To be allowable under Federal awards, costs must meet the following general criteria:
>
> a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
>
> b. Be authorized or not prohibited under State or local laws or regulations.

The Office of Financial Management *State Administrative and Accounting Manual,* Section 85.32.10, states in part:

> . . . At a minimum, agencies are . . . to establish and implement the following:

1. Controls to ensure that all expenditures/expenses and disbursements are for lawful and proper purposes . . . .

The Department's Administrative Policy 13.11, General Contract Monitoring, states its purpose is to provide Department staff with general contract monitoring guidance that can reasonably ensure:

(1) The department receives goods and services that are paid through the contracting process.

(2) The contractor meets the scope of work and specifications identified in the contract.

04-29 The Department of Social and Health Services, Children's Administration, paid through the Social Services Payment System for services performed after a client's date of death.

Background

The Department of Social and Health Services, Children's Administration administers child welfare and licensing services through 45 local offices in six geographic regions. The Administration is responsible for the investigation of child abuse and neglect complaints, child protection, family preservation, family reconciliation, foster care, group care, independent living, and adoption services for children up to 18 years of age.

The Administration can make adoption support payments to adoptive parents when the children being adopted require special assistance beyond the family's financial resources. One source of such funds is the federal Adoption Assistance Program (CFDA 93.659).

Description of Condition

We reviewed amounts paid through the Social Services Payment System for the period July 1, 2003, through December 31, 2003, for services provided after a client's death. We found 79 clients for whom these types of payments appeared to have been made. Services funded through this System with Medicaid dollars were addressed in finding M04-04 in the Special Medicaid Report we issued on December 30, 2004. For services other than Medicaid, we found five instances in which payments were made for care provided after a client's date of death.

We shared our detailed results with the Department and requested any evidence it had that the payments to these providers were allowable. Because the Department did not respond, we selected one of the potential exceptions for further examination.

The selection we made for further testing was a payment to adoptive parents who continued to receive monthly adoption support funds, even though records in the Department's Automated Client Eligibility System showed the child had died in mid-2001.

The Department's Adoption Support Program Manager researched the issue and reported to us that adoption support payments in this case were suspended in February 2004 because the family moved, leaving no forwarding address. On June 24, 2004, the file stated that warrants from October 2003 through January 2004 were returned to the Department as undeliverable. The case, however, was still open, as the Program did not know the client was deceased. Between the child's date of death and the date of our inquiries, the Department paid the adoptive parents a total of $16,549 for 32 months of service.

Cause of Condition

The Department is largely dependent on the provider or family members to voluntarily report a client's death. Lack of timely notification or no notification leads to cases where claims are paid after the recipient has died**.**

Effect of Condition

The Department's inability to identify deceased clients in a timely manner allows payments for deceased clients to continue without timely detection. This leaves the Department susceptible to error or misappropriation. We question the $16,549 paid inappropriately. The Department believes federal and state funds each paid 50 percent of this amount.

Recommendation

We recommend the Department:

- Consider establishing procedures with the Department of Health and with providers that will provide notification of clients' deaths in a timely manner.

- Request that the Division of Fraud Investigations review these payments to determine what further action the Department should take, including setting up an overpayment for collection.

- Ensure the checks returned as undeliverable are properly cancelled.

Department's Response

The Department concurs with this finding. The Department regrets the information developed in response to the auditor's request was not presented in time for the auditor's review and will work to improve timely responses to auditor requests for information.

Children's Administration (CA) staff has initiated contact with the Department of Health to develop a process that provides DSHS with a list of deceased persons in Washington State on a monthly or quarterly basis. The Administration will also develop and implement procedures for timely provider notification of deceased clients.

CA submitted the overpayment request to the Office of Financial Recovery (OFR) on November 19, 2004. Per telephone discussion with OFR staff, the person who received the adoption support checks will be legally served this month. CA will refer this case to the Division of Fraud Investigations for follow-up and has asked OFR to share the overpayment file with the Division of Fraud Investigations.

CA will implement a standardized policy for the handling of undeliverable checks and ensure compliance with existing department policies on cancellation of checks.

Auditor's Concluding Remarks

Since we received the response above, the Department communicated to us that it determined the majority of the checks written after the date of death were cashed. The Department is now determining what further steps it needs to take. We appreciate the Department's prompt and thorough response and its commitment to resolving these issues.

Applicable Laws and Regulations

The Office of Financial Management *State Administrative and Accounting Manual*, Section 85.32.10, states in part:

> It is the responsibility of the agency head, or authorized designee, to certify that all expenditures/ expenses and disbursements are proper and correct. Agencies are responsible for processing payments to authorized vendors, contractors, and others providing goods and services to the agency. Agencies are to establish and implement procedures following generally accepted accounting principles. At a minimum, agencies are also to establish and implement the following:
>
> 1. Controls to ensure that all expenditures/expenses and disbursements are for lawful and proper purposes . . . .

04-30 The Department of Social and Health Services, Mental Health Division, did not comply with state and federal regulations when contracting for services paid with federal Community Mental Health Services Block Grant funds.

Background

The Department of Social and Health Services, Mental Health Division, administers the federal Community Mental Health Services Block Grant (CFDA 93.958), received from the federal Department of Health and Human Services. This Program provides funds to states and territories to help them provide comprehensive, community-based mental health services for adults with serious mental illness and children with serious emotional disturbances. These services may include direct services to clients or other professional/technical services. The Division contracts with service providers and professional and technical contractors to provide Program services.

In fiscal year 2004, the Department spent $8,697,249 in this Program

Federal regulations applicable to the awarding of federal funds to states require the states to follow their own laws and regulations when spending these funds.

Description of Condition

The Division is not in compliance with state regulations regarding contract procurement and therefore is not in compliance with federal regulations. During our review, we found:

- We reviewed four contracts charged to the Program that were classified as personal service contracts in the accounting records. We found two of these were awarded as client service contracts. Based on the Statement of Work within each contract, we determined the services provided under these contracts should have been classified and procured as personal service contracts. In addition, the classification justification for one of the contracts related to a prior year's contract that did not provide the same services.

- We also reviewed contract files to ensure the contracts were executed and approved by both the contractor and the Division prior to the start date of the contract. We identified nine contracts that were not properly executed and approved prior to the start date of the contracts or the performance of work. The lag times between the start dates and the execution and approval dates ranged from several days to several months.

Cause of Condition

Confusion within the Division regarding the difference between the definition of personal services and client services contracts caused the misclassification.

In addition, the Division contracting staff is not always notified until after work has begun of the need for a potential personal or client service contract.

Effect of Condition

The Department cannot ensure the state's resources were used in the most economical manner possible because contracts awarded as client services are not subject to the specific competitive procurement and filing requirements that affect personal services contracts.

We question the $810,862.50 in federal Community Mental Health Service Block Grant funds paid for these contracts in fiscal year 2004.

Recommendation

We recommend the Department review its client service contracts to ensure they meet the definition provided by the Office of Financial Management and, for any that do not, follow appropriate procurement criteria in the future.

We also recommend the Department ensure contracts are properly executed and approved prior to the start date of the contract.

Department's Response

The Department concurs with this finding.

The Mental Health Division (MHD) Chief of Finance has instructed staff to carefully review all contracted services to ensure division contracts are correctly classified and procured.

MHD contract staff will improve tracking of contracts sent for contractor signature and return to the MHD to enable the execution of contracts prior to the start date. The division will issue verbal direction immediately and written instructions by March 15, 2005, to all staff involved in contracts management of the importance of executing contracts prior to the start dates of service.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review these areas in our fiscal year 2005 audit.

Applicable Laws and Regulations

The U.S. Office of Management and Budget's *Cost Principles for State, Local and Indian Tribal Governments*, Circular A-87, Attachment A, Section C states in part:

> 1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
>
> c. Be authorized or not prohibited under State or local laws or regulations . . . .

RCW 39.29.006 states in part:

> (7) "Personal service" means professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement . . .
>
> (8) "Personal service contract" means an agreement, or any amendment thereto, with a consultant for the rendering of personal services to the state which is consistent with RCW **41.06.380.**

The Office of Financial Management's *State Administrative and Accounting Manual,*
Section 15.10.10 states:

> Personal services are to be procured and awarded by state agencies in accordance with the requirements of Chapter 39.29 RCW.

Section 15.10.15 states in part:

> Personal Service – Professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement.

Section 15.10.45 states in part:

> Agencies shall not structure contracts to avoid the competitive procurement or other requirements of this policy.

Section 16.10.15 states in part:

> Client Services – Services provided directly to agency clients including, but not limited to, medical and dental services, employment and training programs, residential care, and subsidized housing. Clients are considered to be those individuals who the agency has statutory responsibility to serve, protect, or oversee. Clients are members of the public, external to state government, who have social, physical, medical, economic, or educational needs. Clients are not providers of services, state employees, or business organizations.

Section 20.20.20 states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

Department of Social and Health Services, Mental Health Division, Policies and Procedures, Policy Statement No. 6.02, states in part:

> Contracts must be submitted to the MHD Contract Manager at least thirty days prior to execution. No contracts will be approved after work has begun.

04-31 The Office of Superintendent of Public Instruction did not comply with state and federal requirements when contracting for services paid with federal Title I funds.

Background

Since 2002, the Office of Superintendent of Public Instruction has been contracting with School Improvement Facilitators to work with school districts and individual school staff, parents and community members to:

- Identify schools strengths and areas of need.
- Develop school improvement plans.
- Develop performance agreements between the individual schools, school districts and the Office.

The Office selects those schools needing support in improving student learning and then contracts with facilitators to help plan improvements. Originally, 25 schools were involved in the three-year process. Each year, schools have been added to the project, bringing the current total to 67 schools involved in various stages. Federal funds are provided to the state through Title I (CFDA 84.010) to assist schools that have not met "adequate yearly progress" for two consecutive school years, as set out in the federal No Child Left Behind Act.

In fiscal year 2004, the Office contracted with and paid 49 Facilitators a total of $2,128,600. Similar contracts totaled $761,000 in fiscal year 2002, $1,117,500 in fiscal year 2003, and $2,006,000 to date in fiscal year 2005. All individual contracts were for amounts of more than $20,000.

State regulations define client services as those services provided directly to those individuals the contracting agency has statutory responsibility to serve, protect, or oversee. Client service contracts are agreements with firms or individuals to provide direct services to clients of the agency. Agencies may select client service contractors by using the most appropriate procurement methods, such as competitive, non-competitive (direct award) or sole source methods.

Personal services consist of professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement. Personal service contracts are agreements with consultants to provide these personal services to state agencies, businesses, providers, other contractors, etc. These contracts are subject to specific competitive procurement and filing requirements. In addition, federal regulations require state grant recipients to follow state laws and regulations as a condition of receiving federal reimbursements.

Description of Condition

The Facilitator contracts do not meet the definition of client service contracts, as the facilitators do not provide direct services to individuals. Although the contracts more nearly meet the definition of personal services than the definition of client services, the Office classified and procured them as client service contracts. This classification was based on the belief that principals and teachers are clients of the Office and that these contracts provided direct services to them.

Before the contracts were first procured in 2001, the Office of Financial Management, without reviewing the actual contracts, verbally concurred with the Office's classification of these contracts. Rather than soliciting competitive bids, as required for contracts over $20,000, the Office of Superintendent of Public Instruction set the price it would pay and then awarded contracts to private individuals and Educational Service Districts. It did not file the required personal service contract information with the Office of Financial Management.

In addition, the contracts provide that, for the work of a minimum number of days, the contractor is to receive established monthly budgeted payments based on the contract total divided by the number of months in the contract period. We found no evidence that, before payment, the Office performed any comparisons between the amounts contractors billed and the minimum number of days of work the contracts required. Instead, the Office relied on contractor filing of quarterly performance reports to support the monthly payments. Quarterly reports do not provide timely support for monthly payments and do not qualify as sufficient evidence to tie performance to the contracted minimum number of days of work.

Cause of Condition

- The Office relied on verbal guidance from the Office of Financial Management regarding the proper treatment of the contracts. It did not review its approach to ensure it complied with the *Guide to Personal Service Contracting Rules and Best Practices*, which the Office of Financial Management adopted in 2002 and which the Legislature made mandatory as of January 1, 2003.

- Contract language is vague regarding the minimum performance required and how that will be reported to the Office. The contracts specify a minimum number of "days" but do not specify what constitutes a day.

Effect of Condition

Although these contracts did not go through the formal bidding process required for personal services contracts, the Office did provide evidence that the contractor selection process met a number of steps required for competitive procurement; therefore, some assurance is provided that the state's resources were used in the most economical manner possible.

With inadequate monitoring, the Office may be providing payments when the contractor provided little or no service in that particular month. However, we did find evidence that services were provided over a period of time.

Based upon sufficient evidence provided to us to support the selection process, the recognition that conflicting guidance was provided, and the evidence that the Office did receive the contracted services, we are not questioning the costs for these contracts.

Recommendation

We recommend the Office:

- Review its client service contracts to ensure they meet the definition provided by the Office of Financial Management and, for any that do not, procure them following the correct criteria in the future.

- Ensure it has received the appropriate services prior to payment and prior to requests for federal reimbursement.

Agency's Response

The Office of Superintendent of Public Instruction (OSPI) partially concurs with this finding. Each element of the finding will be addressed separately.

- *OSPI concurs with the State Auditor that the School Improvement Facilitator (SIF) contracts were classified and procured as 'client' services after relying on conversations with the Office of Financial Management (OFM) regarding the proper treatment of the classification of the contracts.*

- *OSPI does not concur that its only clients are students, as inferred in the finding by the indication we improperly classified the SIF contracts due to the belief that teachers and principals are clients of the office. In most cases OSPI does not directly serve students but provides direct services to school administrators, parents, and teachers in developing the necessary skills to serve K-12 students. Under RCW 28A.300.040, OSPI has supervision over all matters pertaining to the public schools of the state.*

  OSPI will be having further discussions with the Attorney General's Office regarding this issue.

- *OSPI does not concur with the State Auditor that the SIF contracts need to be competitively bid.*

  Chapter 39.29 RCW sets out a general policy of open competition for all personal service contracts entered into by state agencies, unless specifically exempted. Chapter 39.29.040(4) states, in part:

"Contracts awarded for services to be performed for a standard fee, when the standard fee is established by the contracting agency or any other governmental entity and a like contract is available to all qualified applicants."

The only available source for interpretation is the OFM Guide to Personal Services Contracting, Section 4.9.4. Focusing on the plain language of the statute, as further interpreted by OFM's personal service contracting guide, OSPI, and our Assistant Attorney General, we believe that when applied to our SIF contracts it clearly exempts these contracts from the requirements of Chapter 39.29 because the agency (1) established a standard fee of $30,000 per School Improvement Facilitator per eligible school for performance of the work; and (2) made the contract available to all qualified SIF applicants. In this case, the other procurement requirements in RCW 39.29 would not apply to the SIF contracts.

We would emphasize there was no attempt on the part of OSPI to classify the contracts as 'client service' to avoid any formal competitive solicitation. Rather, the agency followed a higher standard than required under 'client services' or the exceptions available to them under 39.29.040(4). After establishing a standard fee based on a fair and defensible market rate for attracting experienced educators which was made available to all qualified SIF applicants, OSPI went out for an informal competitive solicitation to ensure facilitators would be highly skilled and experienced educators with prior success in improving schools.

- *OSPI concurs with the State Auditor that the SIF contract language was vague regarding how many hours constitutes a day. We further concur that for the first two months of each quarter payments made to the SIF contractors lacked proper monitoring and inadequate supporting documentation to ensure services were received prior to payment.*

  Our agency has taken immediate action in establishing a clear definition of how many hours constitute a day. More significantly OSPI is currently working on bolstering supporting documentation for all invoices to ensure it has received the appropriate services prior to any payment being made.

- *We do not agree with the State Auditor's interpretation of the criteria set forth in Office of Management and Budget (OMB) Circular A-87 Section C. Basic Guidelines; 1.c. and 1.j.*

  Section 1.c. sets forth language that for costs to be allowable under Federal awards they must, "Be authorized or not prohibited under State or local laws or regulations." This merely requires that in order for the expenditure to be allowable under federal law, the actual expenditure that occurs must also be for a purpose allowed under state law, or for a purpose not prohibited by state law. Based on this definition, SIF contractor expenditures met the criteria as state law allows for expenditures for contractors to aid schools in school improvement efforts as long as the costs are supported. Further, all SIF contractor expenditures met the federal and state objective of this program which was to improve the teaching and learning of children at risk of not meeting challenging academic standards.

  Section 1.j. sets forth language that costs must be adequately supported. As noted above, all costs were supported by quarterly progress reports.

In closing, we appreciate the work your office does and the recommendations of your staff will be very helpful to ensure we are compliant with all aspects of contracting in the future.

Auditor's Concluding Remarks

The Office of Financial Management advised us that the advice it gave to the Office of the Superintendent of Public Instruction was based upon an incomplete review of these contracts. It now indicates that the types of services provided by the contracts are personal, rather than client, services.

The contracts were not based upon a standard fee that would exempt them from competitive bidding. The cost of the contracts varied from $10,000 to $32,000. Each of the contracts must stand on its own merit and without additional knowledge; a reasonable person would probably not be able to discern a clear relationship in contract

amount to contract duration. The prorating of days and standard amounts is not clearly stated in individual contract language.

The Office of Financial Management's *Guide to Personal Service Contracting* states it is always advisable to use competitive procurement for personal services, since this will favor increased participation by quality professional consultants with a submission of a best offer. It also states that competitive procurement can foster innovative approaches, reduce the accusations of favoritism and provide a more defensible position if contract problems arise.

Fiscal monitoring should be part of an overall monitoring plan to provide assurance that billings relate to the contract terms and that there is sufficient documentation to demonstrate satisfactory delivery of agreed-upon services. Reliance on quarterly reports, which could be received a significant amount of time after payment, is not timely or sufficient monitoring for monthly payments.

We appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

Contracts

RCW 39.29.006 states in part:

> (7) "Personal service" means professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement. This term does not include purchased services as defined under subsection (9) of this section. This term does include client services.
>
> (8) "Personal service contract" means an agreement, or any amendment thereto, with a consultant for the rendering of personal services to the state which is consistent with RCW 41.06.380.

Section 15.10.10 of the Office of Financial Management's State *Administrative and Accounting Manual* states:

- Personal services are to be procured and awarded by state agencies in accordance with the requirements of **Chapter 39.29 RCW**.

Section 15.10.15 of the Manual states in part:

- Personal Service - Professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement.

RCW 39.29.006 (2) states:

> "Client services" means services provided directly to agency clients including, but not limited to, medical and dental services, employment and training programs, residential care, and subsidized housing.

Section 16.10.15 of the Manual expands on this definition:

> Client Services - Services provided directly to agency clients including, but not limited to, medical and dental services, employment and training programs, residential care, and subsidized housing. Clients are considered to be those individuals who the agency has statutory responsibility to serve, protect, or oversee. Clients are members of the public, external to state government, who have social, physical, medical, economic, or educational needs. Clients are not providers of services, state employees, or business organizations.

The Office of Financial Management's *Guide to Client Service Contracting* states in part on page 2:

> Clients are those individuals the agency has statutory responsibility to serve, protect or oversee. Clients are members if the public, external to state government, who have social, physical, medical, economic, or educational needs. These individuals may require government assistance to meet their needs. For example:
>
> - Clients of the Office of Superintendent of Public Instruction include K-12 public school students, and students at the institutions of higher education are their clients.

RCW 39.29.011 states in part:

> - All personal service contracts shall be entered into pursuant to competitive solicitation, except for: . . .
>   (4) Contracts between a consultant and an agency of less than twenty thousand dollars . . . .

RCW 39.29.055 (1) states in part:

> Personal service contracts subject to competitive solicitation shall be (a) filed with the office of financial management and made available for public inspection . . . .

Allowable costs

The U.S. Office of Management and Budget's *Cost Principles for State, Local and Indian Tribal Governments*, Circular A-87, Attachment A, Section C states in part:

> 1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
>
>   d. Be authorized or not prohibited under State or local laws or regulations . . .
>
>   j. Be adequately documented.

Section 85.32.20 of the *State Administrative and Accounting Manual* states:

> Prior to payment authorization, agencies are to verify that the goods and services received comply with the specifications indicated on the purchase documents.

The Office of Financial Management's *Guide to Personal Service Contracting,* Chapter 8-3 and its *Guide to Client Service Contracting,* Chapter 5, page 39 both require contract managers, before authorizing payments, to carefully review contractors' invoices to ensure there is adequate evidence services have been delivered as required.

Item 19 of the General Terms and Conditions section of the School Improvement Facilitators contracts states in part:

> Payments. No payments in advance or in anticipation of services or supplies to be provided under this contract shall be made by the Superintendent. All payments to the Contractor are conditioned upon (1) Contractor's submission of a properly executed and supported voucher for payment, including such supporting documentation of performance and supporting documentation of costs incurred or paid, or both as is otherwise provided for in the body of this contract . . . .

04-32 The Department of Social and Health Services, Mental Health Division, did not comply with state and federal regulations when it inappropriately paid fixed administrative expenditures in advance of services for the Community Mental Health Services Block Grant.

Background

The Department of Social and Health Services, Mental Health Division, administers the federal Community Mental Health Services Block Grant (CFDA 93.958), received from the federal Department of Health and Human Services. This Program provides funds to states and territories to help them provide comprehensive, community-based mental health services for adults with serious mental illness and children with serious emotional disturbances. These services may include direct services to clients or other professional/technical services. The Division contracts with service providers and professional and technical contractors to provide Program services.
In fiscal year 2004, the Department spent $8,697,249 in this Program.

The Division contracted with a vendor to provide training to its clients. Authorized funds for this contract in the amount of $112,000 were to be provided entirely by federal funds from the federal Block Grant. Actual expenditures under this contract were $88,900 from November 2003 through March 2004.

According to the contract, the vendor was to provide Consumer-to-Provider training, job development and recruitment, and consultation and support. The Division was to compensate the vendor for fixed administration costs, student enrollment through the course of the training, and the completion of interval and final reports.

The General Terms and Conditions of the contract stated that the Division would not make payments in advance of the delivery of services by the contractor**.** The Statement of Work in the contract provided for an advance payment by the Division. However, state and federal regulations do not allow advance payments.

Description of Condition

The vendor submitted an invoice and was inappropriately paid an advance of $72,000 for fixed administrative expenditures. This payment was for administrative expenditures for the grant period October 2003 through September 2004. In March 2004, the Consumer-to-Provider training program was terminated due to insufficient applications to support the program.

Cause of Condition

The Division was unaware the contract Statement of Work with regard to advance payments was in conflict with the General Terms and Conditions of the contract and with state and federal regulations.

Effect of Condition

We question the $72,000 in federal funds the Division paid the vendor in advance for services that were never completed.

Recommendation

We recommend the Division comply with state and federal regulations and pay only for allowable services that have been provided.

Department's Response

The Department concurs with this finding

The Mental Health Division will develop and implement policies and procedures, along with a mechanism for oversight, required to comply with state and federal regulations and preclude advance payment of administrative expenditures.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review these areas in our fiscal year 2005 audit.

Applicable Laws and Regulations

The U.S. Office of Management and Budget's *Cost Principles for State, Local and Indian Tribal Governments*, Circular A-87, Attachment A, Section C states in part:

> 1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
>
> e. Be authorized or not prohibited under State or local laws or regulations . . . .

Federal regulations provide an exemption for certain grant programs, including this Block Grant, from federal cost principles, including Circular A-87 mentioned above, provided the state adopts its own cost principles consistent with that circular. The State of Washington has not adopted such principles; therefore, Circular A-87 is the benchmark for regulations related to allocability of costs to federal programs. Attachment A, Section C.3 of the Circular requires allocable costs to be chargeable or assignable in accordance with the relative benefits received.

Washington State Constitution, Article VIII, Section 5, Credit Not To Be Loaned, states:

> The credit of the state shall not, in any manner be given or loaned to, or in aid of, any individual, association, company or corporation.

The Office of Financial Management *State Administrative and Accounting Manual*, Section 85.32.10, states in part:

> It is the responsibility of the agency head, or authorized designee, to certify that all expenditures/ expenses and disbursements are proper and correct. Agencies are responsible for processing payments to authorized vendors, contractors, and others providing goods and services to the agency. Agencies are to establish and implement procedures following generally accepted accounting principles. At a minimum, agencies are also to establish and implement the following:
>
> 1. Controls to ensure that all expenditures/expenses and disbursements are for lawful and proper purposes . . . .

The contract General Terms and Conditions and Statement of Work states in part:

> . . . the Contractor shall manage the contract budget in such a way that will guarantee sufficient funds to cover the period of performance . . .
>
> . . . DSHS shall not make any payments in advance or anticipation of the delivery of services to be provided pursuant to this Contract . . . .

04-33 The Department of Social and Health Services does not have adequate internal controls over the processing of expenditures through the Agency Financial Reporting System.

Background

The Agency Financial Reporting System is the state of Washington's official accounting system. State agencies are required to enter their financial data, including accounts payable, into this System. This System is a payment system that charges several funding sources one of which is federal. The System has security features that, when used effectively, can reduce the risk of error or fraud in financial transactions.

Designated security administrators in each agency are responsible for determining the level of access granted to individuals within the agency and for removing access when appropriate. Access controls are available with the System to preclude any one person from having total control over a particular type of transaction.

During our previous audit, we identified and reported internal control weaknesses related to access to the System.

Description of Condition

This year we followed-up on last year's finding to determine if improvements over access had been made. We reviewed the types of System access the Department has granted to employees with accounts payable functions and found the Department still does not take advantage of the System's internal control features that allow for an adequate segregation of duties. The Department has not established and followed written policies and procedures that would require an adequate separation of duties and timely access changes in any of its offices with an accounts payable function. Access to the accounts payable function is not secure, as described below.

a. We found that 663 Department employees have the capability to enter and approve payment batches, with no management review required. (Last year the number of these employees was 632.) All of these employees can process a fictitious payment without oversight or approval by anyone.

b. In addition, all 663 employees are capable of processing payments to unauthorized vendors by using certain designated codes. These employees have the ability to generate a warrant to anyone they choose. For the period July 1, 2003, through January 31, 2004, payments processed through these codes amounted to $17,399,607.

c. We noted that 605 of the 663 employees also have the access needed to recall certain batch types for error correction. An employee could recall and change his or her batch as well as recall and change another employee's batch.

d. The Department's System security administrators rely on management in the hundreds of Departmental offices to notify them of requests for access, changes in access, and terminations of access. Currently, this communication is not successful. We identified 9 terminated employees who still had access to the accounts payable function. We found one employee who has been working for the State Auditor's Office since April 2004 but who still had access until November 2004.

   Former employees working for other state agencies would have an especially easy opportunity to access the Department's accounts payable and prepare or alter transactions.

e. The Department does not require that an employee independent of the process reconcile output data to the data that should have been entered into the System.

All of these conditions were also reported in last year's State Accountability Report.

Cause of Condition

The Department stated in its response last year that it does not concur with our concerns or recommendations, except for condition d. It believes it has adequate compensating controls for the other weaknesses we found. We analyzed the response in last year's State Accountability Report and concluded that the controls it described did not adequately alleviate the risks.

Effect of Condition

These control weaknesses increase to a high degree the risk that error or misappropriation could occur and not be detected by management in a timely manner, if at all.

Recommendation

We recommend the Department develop and follow written policies and procedures for its accounts payable function that would ensure:

- An adequate separation of duties for those involved in making payments in the System.
- Timely changes to and removals from System access when appropriate.

Department's Response

The Department partially concurs with this finding. As the Department responded last year, the finding is based solely on the review of system security accesses and there was no review of compensating internal controls the Department has in place. This is a general fault within the Agency Financial Reporting System itself.

The finding asserts inadequate internal controls based solely on the Department's decision to not implement segregation of duties based on system access. The Department believes exhaustive compensating controls are employed to provide sufficient internal control over the processing of expenditures. No audit testing of these compensating controls was conducted and no evidence has been presented to assert or document the generally accepted compensating controls in place are insufficient.

Auditor's Concluding Remarks

As stated in last year's concluding remarks, we did evaluate what the Department believes to be adequate compensating controls. We concluded then and still believe that the Department does not have adequate controls to compensate for its lack of system segregation. We analyzed the Department's compensating controls as follows:

1. The Department stated it has employees who make payments and those who only use the system to make accounting adjustments. This, in the Department's opinion, is a compensating control because it limits the number of individuals who can make payments.

   However, the system does not have controls that would allow for this type of separation of duties. If an individual has access to enter and approve a journal voucher for accounting adjustments, that same individual also has access to create and release a payment. The only difference between a journal voucher entry and a payment entry is the AFRS transaction code that is used. There are no restrictions on transaction codes used by individuals with AFRS access.

2. The Department stated that all transactions are required to have review and approval prior to input into the system.

   This is insufficient because nothing prevents someone from bypassing procedures and simply entering and approving a fraudulent payment, without any prior review.

3. The Department stated it reviews transaction registers, which are the records of payments.

After-the-fact reviews are helpful but not as strong a control as separation of the entry and approval process. Small agencies may have no choice but to perform after-the-fact reviews because there is insufficient staff to properly segregate entry and release system access. However, with approximately 18,000 employees, the Department is Washington's largest state agency and pays out millions of dollars a day. It is usually more difficult, more expensive, and less successful to recover a payment already made than it is to prevent that payment in the first place. This control is not sufficient for the Department.

4. The Department stated that payment distribution is segregated from those who have incompatible system access.

   In such a large agency with so many payments, it is unlikely an inappropriate payment would be caught simply because someone else mails the payment. In addition, the Department pays many vendors by electronic fund transfers. In that process, there are no payments to be distributed. The risk exists that someone with incompatible access could create a fraudulent payment and electronically deposit the payment into a personal bank account.

The Department's decision to disregard available system access controls puts the agency employees at risk and increases its audit costs. The fewer payment controls an agency establishes, the greater the risk of misappropriation or error and the greater amount of testing an auditor must perform. We reaffirm our finding.

Applicable Laws and Regulations

The State of Washington Office of Financial Management's *State Administrative and Accounting Manual*, Section 20.20.20.a states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

Section 20.20.70.a states in part:

> Control activities are the policies and procedures that help ensure management directives are carried out.
>
> **Segregation of duties** - Duties are divided, or segregated, among different people to reduce the risk of error or inappropriate actions. For example, responsibilities for authorizing transactions, recording them, and handling the related assets should be separated.

04-34 The Department of Social and Health Services does not have adequate internal controls over the Social Service Payment System.

Background

The Department of Social and Health Services developed the Social Service Payment System in the late 1970s to:

- Authorize the delivery and/or purchase of social services for clients.
- Collect social services client data required for state and federal reporting.
- Initiate the payment process for purchased services.

The System is used by approximately 3,500 social workers across the state to authorize payments and collect information about services provided to more than 210,000 clients. The system authorizes payments in excess of $1 billion annually to more than 109,000 service providers and those payments charge federal and state funds.

The System is the largest cross-divisional services-based system in the Department and supports payments and management information authorized by Children's Administration, Aging and Disability Services Administration, and Economic Services Administration. The System runs on a UNISYS mainframe computer system and interfaces with a number of other department systems.

Description of Condition

We reviewed controls over electronic access to the Social Service Payment System. We also followed up on weaknesses in application controls that we communicated to management at the end of our last audit. Application controls are those that ensure the accuracy, integrity and completeness of the input, processing, and output of transactions.

During our current review of electronic access to the Social Service Payment System on the UNISYS mainframe, we found the following weaknesses:

- UNISYS does not record the creator or modifier of each transaction. The Department cannot determine accountability for transactions created or updated within the mainframe.
- The Department does not have adequate controls over electronic access to the Social Service Payment System.
    - UNISYS is not capable of generating a list of operator identification (ID) and the associated user name. Because of this weakness, the Department maintains a separate database of user names, operator IDs, and access rights as a compensating control. However, our tests indicate that the database is not a complete and accurate record of users of the Social Service Payment System.
    - The Department uses "generic" (shared) Social Service Payment System operator IDs and passwords to allow inquiry-only access to the System databases; this significantly increases the possibility of unauthorized access to confidential information.
    - Six individuals have more than one operator ID. Assigning duplicate operator IDs allows users additional access that is not required for performance of their assigned duties.
    - System passwords are a minimum of four characters with a maximum of eight characters. The Information Services Board's *Information Technology Security* S*tandards* define "hardened" passwords as having a minimum of eight characters.

- The Department is not using a "lock-out" mechanism to deter access to the System. Lock-out mechanisms limit the number of unsuccessful attempts to log-in to a computer system. Without a limit on authentication attempts, unauthorized users have a much greater chance of cracking passwords.

- The Department does not have adequate controls in place to limit users establishing providers (vendors) in the System to the electronic access necessary to perform their assigned duties. A service provider must be established in the provider file in order to receive payment for services. The provider file input function was recently centralized to limit access to individuals in the Provider File Unit at headquarters. However, 32 operator IDs with access to provider file input are still assigned to individuals outside the Provider File Unit.

- Thirteen operator IDs have provider file input access rights and access rights that authorize payments to providers. The Department's policy is that no worker may have access to both authorization input and provider file input. Operator IDs that have provider file input access rights and authorization input access rights would be able to establish a provider and then authorize payment to that provider.

We found that many of the previous weaknesses in application controls still remain.

- The Department is not performing reconciliations of Social Service Payment System records.

  - The System does not contain transactions or other information on payments that required manual intervention or adjustment. This results in inaccurate and incomplete payment information in the System payment history and summary reports.

  - Not all input forms are accounted for through the daily reconciliation process. Therefore, payment authorizations can be created or changed without supporting documentation.

  - Expenditures authorized through the System are not reconciled to financial records in the state's Agency Financial Reporting System.

- The Department does not have adequate controls over authentication of users with access to the system.

  - The Social Service Payment System does not require users to change the operator ID password periodically; this increases the opportunity for inappropriate access to the System.

  - Authorization of payments requires an additional identifier called a worker ID. Worker IDs are not password-protected. A person with input access to the System can use another individual's worker ID to create or change a payment authorization.

  - When a worker initiates or changes a payment authorization, the System does not require the worker to enter his or her own worker ID. If someone uses the worker ID of another individual, there is no audit trail to establish accountability.

  - There is no read-only access to the computer input screen that is used to add, delete, and view worker IDs. All individuals with access to this screen can add and delete worker IDs.

- The Department does not have adequate controls over Social Service Payment System computer programs.

  - The software that controls the changes to the System computer programs does not adequately maintain a record of the changes. Accountability cannot be assigned for program changes.

  - Department personnel can re-point Executive Control Language. This could result in unauthorized computer programs being run.

- Authorization for payment can be made for service providers designated as closed, deceased, or otherwise restricted. This could lead to payments to providers who should no longer be receiving them.

- The information displayed on System user screens is not appropriate to meet Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.

- The Department exceeds the allowable error rate on information returns (1099-MISC) filed with the Internal Revenue Service; this may result in monetary penalties.

Cause of Condition

The Social Service Payment System is a 25 year old legacy system with 300,000 lines of code in Cobol programming language. It is limited by its original design with minimal security and lack of Unisys software to track transactions created or updated within the mainframe. The system is inadequate and unable to perform higher level functions that today's technology requires.

Effect of Condition

These control weaknesses increase to a high degree the risk that error or misappropriation could occur and not be detected by management in a timely manner, if at all.

Recommendation

We recommend the Department establish and follow adequate internal controls over the Social Service Payment System.

Department's Response

The Department concurs with the finding. As was noted in the State Auditor's Office findings, the Social Services Payment System (SSPS) was developed in the late 1970's using a Unisys mainframe operating system. This system was state of the art at that time. Twenty five years later, expectations and features in systems have changed dramatically. The Unisys system has not allowed for many of the new specifications and features that are needed to meet today's secure payment system environment requirements. Recommended changes to the Unisys system would require software applications that are not available on today's market or would not function to provide the results desired by the State Auditor's Office. The Department has made several attempts to obtain the necessary funding through the Legislature to replace the aging and limited Unisys system without success.

The Department believes we have made and are making good faith efforts to resolve and correct the weaknesses in the SSPS system as defined by the State Auditor's Office. Many issues identified in the audit have been acted upon. For more difficult issues, solutions or alternatives have been investigated and are being put into practice as current work assignments progress. The most notable change will be a rewrite of the SSPS front-end system, WebConnect. Design changes in WebConnect will allow for implementation of many of the security and access features and controls listed by the State Auditor's office. Additional changes will take more time to enact: new development of programs, or the purchase and installation of commercial software as it becomes available on the market. The SSPS system presents many challenges in finding solutions to meet current day expectation however; the Department is making every effort to follow the recommendations as set forth by the State Auditor's Office.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review these areas in our fiscal year 2005 audit.

Applicable Laws and Regulations

The State of Washington Office of Financial Management's *State Administrative and Accounting Manual*, Section 20.20.20.a states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

The Washington State Department of Social and Health Services' *Information Technology Security Policy Manual,* Chapter 4: Access Security, Identification, & Authorization, states in part:

> 4.2.2 AUTHENTICATION REQUIREMENTS
> **Policy Statement 4.2.2**
>
> Adequate controls must be in place to authenticate users accessing department computers, networks, and applications; see DSHS IT Security References R4.2.2 Authentication Requirements, for further detail.
>
> **Standards**
>
> **S1.** Users and other entities such as applications or servers must be authenticated using such methods as login IDs and passwords, digital certificates, smart cards, or tokens.
>
> 4.2.3 USER IDS
>
> 4.2.3.1 General User ID Requirements
> **Policy Statement 4.2.3.1**
>
> Each system or application must have established procedures to ensure that each user ID is uniquely associated with a user. . . .
>
> **Standards**
>
> **S1.** Electronic access to confidential information will always be protected, at a minimum, by a unique user ID, and a password that is constructed and protected as required by section 4.2.4 Use and Construction of Passwords.
> **S2.** Assigning duplicate user IDs or sharing user IDs is prohibited, except that generic user IDs with limited access privileges may be used for:
> Maintenance, troubleshooting, or system monitoring;
> Training;
> Shared workstations in secured areas, where no classified data is accessible unless all users have identical access needs; or
> Program batch runs.
> **S3.** Users shall not be assigned or be allowed to use bogus user IDs (a user ID created under a fictitious name). This does not prohibit the use of test user IDs . . . .
>
> 4.2.4.1 General Password Requirements
> **Policy Statement 4.2.4.1**
>
> Users and system administrators must be informed of the importance of constructing safe passwords and protecting them from unauthorized disclosure; see DSHS IT Security References R4.2.2 Authentication Requirements.

Standards . . .

S4. Change passwords at least every 120 days or more often when required by the system. Where the feature is available, system administrators must configure systems to prompt users to change their passwords when they have expired. . . .

S11. Where possible, password rules must be systematically enforced, including configuring systems so that:

a. Entry of passwords on the screen is not viewable (i.e. a character such as the * is used to hide the actual keyed entry.)
b. Passwords are encrypted during storage and transmission using at least 128-bit encryption.
c. A "lock-out" mechanism is activated after a maximum of up to five unsuccessful authentication attempts.

The Washington State Department of Social and Health Services' *Information Technology Security Policy Manual,* Chapter 6: System Design, Development, Maintenance, and Operations, states in part:

6.2.1 SECURITY REQUIREMENTS DURING DESIGN AND DEVELOPMENT

Policy Statement 6.2.1

IT security must be an integral part of the system development or acquisition process. See DSHS IT Security Procedures P6.2.1 Internet Based Applications, for details.

NOTE: Failure to address and specify security requirements early in a project increases the likelihood that security will prove to be inadequate or that additional costs will be incurred.

Standards

S1. Staff will:

a. Identify the category of data (see Chapter 3, Classifying and Protecting Data and IT Resources) to be processed or accessed by the system.
b. Ensure that appropriate IT security measures are included in the design of the system from the beginning of the project, and
c. That plans for securing the system are included in the system's documentation.

S2. Where audit trails recording access to information are required, managers or developers must design applications such that the audit trails will be secure, and easily maintained and reconstructed.

6.2.3 APPLICATION ACCESS AND PRIVILEGES

Policy Statement 6.2.3

Access privileges for each employee must be controlled to ensure that the employee can only access those applications and processes needed in the performance of his or her duties.

Standards

S1. Operations Managers must require all applications on DSHS mainframe or client server systems to be regulated by standard access control systems software such as RACF, SIMAN and Security Option 1 for the UNISYS, or SAM for Windows.

NOTE: Access control systems software can be:

a. A feature of an operating system
b. An add-on access control package
c. A front-end or firewall that performs access control

S2. A user's session must initially be controlled by access control systems software, and, if defined permissions allow it, control will then be passed to separate application software.

S3. Managers of mainframe operations must ensure that operators are limited to only those system options for which they have privileges.

S4. Managers of mainframe operations must separate work duties and responsibilities of employees in the data control center, including input/output processing, production control, and operations.

S5. No modifications by operations staff to production data, production programs, or the operating system are permitted.

S6. Only authorized maintenance personnel may access the production library. Controls must be in place to prevent unauthorized use or removal of tape files, diskettes, and other media.

6.2.4 MODIFYING MAINFRAMD PRODUCTION SYSTEMS

Policy Statement 6.2.4

Managers of operations must employ a formal change control procedure to ensure only authorized changes are made to computer production processing at DSHS.

Standards

S1. Establish and document a system change control procedure.

S2. Requests for changes to production programs or systems shall be in writing. This may be done by e-mail so long as the recipient of the request confirms its authenticity, e.g. by phone.

S3. Provide operations staff with adequate training and operating documentation before a system is moved into production processing.

Policy Statement 6.2.5

Managers of IT operations must require logs to be maintained for DSHS production application systems.

Standards

S1. All computer systems running DSHS production application systems must include logs which record:

a. Changes to critical application system files
b. Additions and changes to the privileges of users
c. System start-ups and shutdowns
d. Attempted system access violations

S2. It must be possible to reconstruct activities from operation logs . . . .

04-35 The Department of Social and Health Services, Economic Services Administration, does not enter accurate information in its Random Moment Time Sample to ensure administrative costs are properly charged to federal and state funds.

Background

The Department of Social and Health Services uses 12 cost allocation methods in its federally approved Public Assistance Cost Allocation Plan. Staff effort is allocated to several programs based on a variety of methods. We reviewed the Random Moment Time Sample method during our fiscal year 2004 audit of cost allocation at the Department.

This method estimates the allocation of the social workers' time to federal or state programs that benefit from this staff effort. The U.S. Department of Health and Human Services prefers this method when staff members perform many different activities on a variety of programs over a short period of time. The Department has a specific policies and procedures manual explaining how to use the method that is included in the Public Assistance Cost Allocation Plan.

The method requires the use of valid statistical data to ensure a proper allocation of administration costs to the various programs. The plan must be followed to make certain a valid statistical sample is used and the proper results are entered into the allocation program. If the data is invalid, the accuracy of the allocation of administrative costs to various federal and state programs cannot be assured.

During the monthly process, coordinators are to distribute and gather applicable survey documents. Selected workers are to complete the surveys with information describing the services they are performing at the survey times. When this data is entered in the system, it is used to distribute administrative costs to federal and state programs for the month.

The Department uses this method for both the Economic Services Administration and Children's Administration. During our audit, we concentrated on the Economic Services Administration's system. The Administration uses the system to allocate employees' time to several programs, including Temporary Aid to Needy Families, Refugee Cash Medical, Childcare and Development Fund, Social Service Block Grant, Medicaid, and Food Stamps.

Description of Condition

We found that the data collected for the system was not accurate. Many survey documents were not completed accurately according to instructions, invalidating the data. Other survey documents were not retained to serve as support for the charges. We reviewed 1,109 of 4,466 survey documents completed during a three-month period and found 503 exceptions, a 45 percent error rate; of these, 356, or 32 percent, affected federal funds.

Cause of Condition

Coordinators and staff members selected to complete the survey documents have not received adequate training. In addition, these individuals often do not know about the manual that explains how to complete the documents properly. Further, when an error is made, management does not always explain the error to the staff member so it will not reoccur. In some cases, the Community Services Office administrator does not monitor this process.

Effect of Condition

Several federal programs in the Administration rely on the system for the allocation of administrative charges:

Federal Program and CFDA Number	Federal Portion	State Portion	Total fiscal year 2004 Administrative Costs
TANF (93.558)	26,676,581	36,907,772	63,584,353
Refugee Cash Medical (93.566)	1,791,777	0	1,791,777
CCDF (93.596)	6,248,951	6,248,952	12,497,904
SSBG (93.667)	4,475,373	10,879,180	15,354,552
Medicaid (93.778)	32,640,285	32,383,915	65,024,200
Food Stamps (10.561)	29,483,273	29,483,273	58,966,546
STATE ONLY	0	8,018,554	8,018,554
Report Total	101,316,240	123,921,645	225,237,885

Since the Department cannot be sure that administrative costs are being charged accurately to these programs, we are questioning the $225,237,885 in costs shown above.

Recommendation

We recommend that the Department provide training to the coordinators and staff who may be selected as part of the statistical sample used to determine administrative expenditures for the above programs. In addition, we recommend the manual that includes the policies and procedures be available to these employees. We further recommend that Community Service Office administrators monitor the process.

Department's Response

The Department partially concurs with the finding.

A. The State Auditor's report for the Economic Services Administration (ESA), Random Moment Time Sample (RMTS) process states the survey documents were not completed accurately. However, it does not give specific information to adequately identify and address the issues. In our review of the copies of the RMTS documents sent to the Division of Management and Operations Support from five offices for the State Auditor to review, not filling in the time or signing the documents were the main items we found to be in error. While staff may not have followed all instructions for completing the documents this does not invalidate the task reported. An example would be not completing the assigned time. If staff completed the document at the assigned time they may not have seen the need to fill in the time, but rather thought they needed to fill this in only when there were completing the document later than the assigned time.

B. The expenditures are incorrectly questioned. Even if the questioned RMTS documents were excluded from consideration, there would be no impact to our actual expenditures. Excluding the questioned RMTS documents would result in the minor shifting of expenditures from one federal funding source to another.

C. The Department concurs with the recommendations the auditor provided concerning the RMTS process. ESA will provide additional training to staff to ensure staff understands the entire RMTS process. This training will include providing the policies and procedures manual to all employees involved in the RMTS process. Also, Community Service Office Administrators will be informed of their requirement to monitor the RMTS process.

Auditor's Concluding Remarks

We reaffirm our finding. The Random Moment Time Sample method requires the use of valid statistical data to ensure a proper allocation of administration costs to various federal programs. Many survey documents were not accurately completed. If the preparer does not sign or note the time completed, the Department has no assurance the correct person completed the information at the proper time. This situation invalidates the data, leading to an invalid statistical sample and possible invalid federal program charges.

When this occurs, the risk is high that one federal program may pay for expenditures that should have been allocated to a different federal program. In such a case, the costs would not be allowable for the paying program. We agree this would not change the total expenditures for the Department; however, it could significantly change the federal agency reimbursing for the costs. The issues of allowability and allocability for specific programs are highly significant to federal funding sources.

We appreciate that the Department concurs with our recommendations and plans to establish a training program and additional monitoring for this cost allocation process.

Applicable Laws and Regulations

Title 45 Code of Federal Regulations, Subtitle A (10-1-03 Edition), Section 95.507 - Plan Requirements, sub-section (b.8) states in part:

> . . . an adequate accounting and statistical system exists to support claims that will be made under the cost allocation plan . . . .

Section 95.517 - Claims for Federal Financial Participation, sub-section (a) states in part:

> A State must claim FFP for costs associated with a program only in accordance with its approved cost allocation plan

Section 95.519 - Cost Disallowance states in part:

> If costs under a Public Assistance program are not claimed in accordance with the approved cost allocation plan (except as otherwise provided in Sec. 95.517), or if the State failed to submit an amended cost allocation plan as required by Sec. 95.509, the costs improperly claimed will be disallowed.
>
> . . . (b) If the issue affects the programs of more than one Operating Division, or Federal department or the State, the Director, DCA, after consulting with the Operating Divisions, shall determine the amount inappropriately claimed under each program. The Director, DCA will notify the State of this determination, of the dollar affect of the determination on the claims made under each program, and will inform the State of its opportunity for appeal of the determination under 45 CFR part 16. The State will subsequently be notified by the appropriate Operating Division as to the disposition of the funds in question.

Section 74.53 - Retention and access requirements for records, sub-section (b and c) states in part:

> Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of three years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report.

The U.S. Office of Management and Budget's Circular A-87, Attachment B, (11.h) - Support of Salaries and Wages, states:

> (6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.
>
> (a) Substitute systems which use sampling methods (primarily for Aid to Families with Dependent Children (AFDC), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:
>
> (i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection (c);
>
> (ii) The entire time period involved must be covered by the sample; and
>
> (iii) The results must be statistically valid and applied to the period being sampled.

The Implementation Guide for Circular A-87, ASMB C-10, (http://www.hhs.gov/grantsnet/ state/asmbc10.pdf), issued on April 8, 1997 by the U.S. Department of Health and Human Services, subsection 3-21, states in part:

> . . . a statistical reporting system (e.g. random moment sampling) should be considered for employees working in dynamic situations (performing many different types of activities on a variety of programs over a short period of time).

04-36 The Department of Social and Health Services did not comply with federal requirements for an independent peer review of the Community Mental Health Services Block Grant.

Background

The Department of Social and Health Services, Health and Rehabilitative Services Administration, administers the federal Community Mental Health Services Block Grant (CFDA 93.958), received from the federal Department of Health and Human Services. This Program provides funds to states and territories to help them provide comprehensive, community-based mental health services for adults with serious mental illness and children with serious emotional disturbances.

In fiscal year 2004, the Department spent $8,697,249 in this Program. Approximately 95 percent of this amount was awarded to Regional Support Networks and other contractors who administer the Program throughout the state.

Special terms and conditions of the federal grant require a state to provide an independent peer review of the Program to assess the quality, appropriateness, and effectiveness of treatment services provided to individuals. At least 5 percent of the entities providing services must be reviewed annually and they must be representative of the entities providing the services.

Description of Condition

We found the Administration is not complying with the requirement for an independent peer review of the Program.

Cause of Condition

The Administration stated it received verbal guidance from the Community Mental Health Services Division of the Department of Health and Human Services that the independent peer review requirement is not an effective or efficient method of reviewing the program. Therefore, the Community Mental Health Services Division is not requiring states to follow this requirement. However, the requirement remains in effect in the federal regulations and is still included in the federal guidance provided to auditors.

Recommendation

We recommend the Department comply with the requirements for an independent peer review or petition the federal grantor to change its regulation.

Department's Response

The Department concurs with this finding. The Mental Health Division has petitioned for the federal grantor to change its regulation.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review these areas in our fiscal year 2005 audit.

Applicable Laws and Regulations

Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.] Section 1943 states in part:

(a) The State will – (1)

(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved: and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities); . . . .

04-37 The Department of Community, Trade and Economic Development did not comply with federal requirements for suspension and debarment.

Background

The Department of Community, Trade and Economic Development administers the federal Home Investment Partnership Program (CFDA 14.239), also referred to as the HOME program. The objectives of the HOME program are to:

- Expand the supply of decent and affordable housing, particularly to low- and very-low-income residents.
- Strengthen the abilities of state and local governments to provide adequate supplies of affordable housing.
- Provide financial and technical assistance to states.
- Strengthen partnerships among governments involved with providing affordable housing.

The Department reported total HOME expenditures of $12,810,816 for fiscal year 2004. Approximately 90 percent of these expenditures were awards passed through to subgrantees, such as local governments and non-profit organizations.

Federal grantors prohibit recipients of federal awards from contracting with entities that have been suspended or debarred from receiving federal funds. The federal government can debar a party for convictions for fraud, anti-trust violations, forgery, or other offenses indicating a lack of business integrity or honesty; a history of failure to perform agreements; or a failure to pay a substantial debt. Suspension is usually a preliminary step that may lead to debarment.

New federal regulations effective in November 2003 offer three options for grant recipients to verify that proposed contractors are not suspended or debarred. In addition, grant recipients must inform their subgrantees that they are responsible for following the same suspension and debarment requirements.

Description of Condition

The Department is not in compliance with federal suspension and debarment requirements. The Department chose the option to include a descriptive clause or condition in the contracts for two sections of the HOME program: Tenant Based Rental Assistance and Housing Repairs and Rehabilitation Program. The Department failed to include a notification that the subgrantees also have responsibilities regarding suspension and debarment when they make further awards. We estimate the payments related to these two sections of HOME during fiscal year 2004 totaled $4.5 million. This condition was previously reported in the fiscal year 2003 State Accountability Report and the State of Washington Single Audit Report.

Cause of Condition

The Department believed that the requirement to pass on this information to subgrantees applied only in the case of construction contracts. In addition, employees followed Office of Financial Management preliminary guidance, rather than fully researching the new regulations.

Effect of Condition

Subgrantees' lack of knowledge could make them susceptible to receiving their own audit findings if they also fail to follow suspension and debarment requirements. The Department may be liable for any amounts paid by the subgrantees to contractors who have been suspended or debarred from receiving federal funds.

Recommendation

We recommend the Department review its contracts for the HOME program to ensure they comply with the new suspension and debarment requirements

Department's Response

We disagree with the finding. The Housing Division believes that it complies with the US Department of Housing and Urban Development's Title 24 of the Code of Federal Regulations, Sections 24.300, 330 and 440. The Housing Repairs and Rehabilitation Program (HRRP) in its contract Specific Terms and Conditions and General Terms and Conditions sections references compliance with Executive Order 12549, Debarment and Suspension, as well as requiring contractors to certify that neither the organization nor its principals are ". . . presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency." In addition, the Conditions prohibit the contractor from entering into contracts with parties that are suspended or debarred and require the Contractor to maintain records of certifications concerning debarment and suspension of construction contactors.

The Housing Division's contractors for the Tenant Based Rental Assistance program (TBRA) are responsible for the determination of low-income family eligibility to receive rental assistance and pay for the family's rent with vouchers directly to landlords. They do not deal with lower tier contractors.

Auditor's Concluding Remarks

Under a grant from the federal government to a state, the suspension and debarment requirements apply to all of the state's awards to subgrantees and, effective November 26, 2003, to contractors receiving individual state contracts for $25,000 or more, a decrease from the prior threshold of $100,000. In addition, the state's contract language must notify its subgrantees and contractors of their responsibilities to pass down suspension and debarment requirements to all of their sub-subgrantees and to their contractors with individual contracts of $25,000 or more. The term "contractors" does not refer only to construction-related contracts.

We reaffirm our finding that the contract language regarding suspension and debarment in the HOME program contracts is inadequate.

Applicable Laws and Regulations

Title 45 of the Code of Federal Regulations, Section 76.300 states:

> When you enter into a covered transaction with another person at the next lower tier, you must verify that the person with whom you intend to do business is not excluded or disqualified. You do this by:
>
> a) Checking the EPLS (Excluded Parties List System)
>
> b) Collecting a certification from that person if allowed by this rule
>
> c) Adding a clause or condition to the covered transaction with that person.

45 CFR 76.330, subpart C states:

> Before entering into a covered transaction with a participant at the next lower tier, you must require that participant to –
>
> a) Comply with this subpart as a condition of participation in the transaction. You may do so using any method unless section 76.440 requires a specific method be used.
>
> b) Pass the requirement to comply with this subpart to each person with whom the participant enters into a covered transaction at the next lower tier."

45 CFR 76.440 states:

> To communicate the requirements to participants, you must include a term or condition in the transaction requiring the participant's compliance with subpart C of this part and requiring them to include a similar term or condition in lower tier covered transactions.

04-38 The Department of Community, Trade and Economic Development did not comply with federal requirements for time and effort reporting.

Background

The Department of Community, Trade and Economic Development administers the Low Income Home Energy Assistance Program (CFDA 93.568), referred to as LIHEAP, and the Community Services Block Grant (CFDA 93.569). While the majority of program payments are for services, both programs also receive some funding for administration.

The goals of LIHEAP are to assist low-income households to:

- Meet the costs of heating and cooling their homes.
- Improve energy self-sufficiency.
- Reduce their vulnerability arising from energy needs.

The target population is low-income households with the highest home energy costs or needs in relation to income, taking family size into account. Other targets are low-income households with members who are vulnerable, such as the elderly, disabled, and young children. The Department reported total LIHEAP expenditures of $38,279,533 for fiscal year 2004.

The Community Services Block Grant can be used to fund programs and other activities that:

- Assist low-income individuals and families attain self sufficiency.
- Provide emergency assistance.
- Support positive youth development.
- Promote civic engagement.
- Improve planning and coordination among multiple resources to address poverty-related conditions.

Funding is used for such services as employment, self-sufficiency, housing, education, income management, health, nutrition, transportation, and links to other resources. The Department funds 31 Community Action Agencies, which assist over 450,000 low-income individuals annually. Community Services Block Grant expenditures for fiscal year 2004 were $6,723,564.

For payroll costs charged directly to federal awards, federal regulations require employees to document their time and effort spent on each federal activity monthly. These monthly records must reflect the actual after-the-fact distribution of the employee's activities. States may charge by budget only if they compare the budget to actual activities at least every three months and adjust requests for federal funds accordingly.

Description of Condition

During our review of payroll charges, we found 13 employees in the LIHEAP and Block Grant programs who worked on multiple activities but charged their time based on budgeted, rather than actual, amounts, without proper periodic adjustments. The total salaries and benefits charged to LIHEAP and the Community Services Block Grant based on budget are estimated to be $113,000; of this amount, $41,000 is attributable to LIHEAP and $72,000 is attributable to the Community Services Block Grant. This condition for LIHEAP was previously reported in finding 03-2 in the fiscal year 2003 State of Washington Single Audit Report.

Cause of Condition

Management believes the estimated time charged to the awards closely approximates actual hours worked.

Effect of Condition

Without proper time and effort records, the Department is unable to substantiate the accuracy of the payroll costs charged to these two programs. We are questioning the approximately $41,000 in federal funds charged to LIHEAP and the $72,000 charged to the Community Services Block Grant.

Recommendation

We recommend the Department maintain time and effort records that comply with federal regulations or perform at least a quarterly reconciliation of estimated to actual hours. We also recommend the Department consult with the federal grantor to determine whether any questioned costs should be repaid.

Department's Response

We agree with the finding. Until CTED has approved cost allocation plans, staff that work on more than one program will charge their time based on actual time spent on the various projects.

Management is confident that the time charged to the noted programs reflects the actual efforts expended and did not cause overcharges to any program. These changes will be completed by December 31, 2004.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding. We also appreciate the cooperation extended to us throughout the audit by the Department staff.

Applicable Laws and Regulations

For certain grant programs, including LIHEAP and the Community Services Block Grant, federal regulations give an exemption from federal cost principles, provided the state adopts its own cost principles consistent with federal requirements. The federal Department of Health and Human Services, Office of the Inspector General has provided us with guidance that it considers the U.S. Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments* to be the benchmark for state cost principles. The state of Washington has not adopted its own cost principles in conformance with this Circular.

Attachment A, Section C.3 of the Circular requires allocable costs to be chargeable or assignable in accordance with the relative benefits received.

Attachment B, Section 8(h) of the Circular states in part:

1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

2) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation...unless a statistical sampling system or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

    a) More than one Federal award,
    b) A Federal award and a non-Federal award,
    c) An indirect cost activity and a direct cost activity,
    d) Two or more indirect activities which are allocated using different allocation bases, or
    e) An unallowable activity and a direct or indirect cost activity.

3) Personnel activity reports or equivalent documentation must meet the following standards:

    a) They must reflect an after-the-fact distribution of the actual activity of each employee,
    b) They must account for the total activity for which each employee is compensated,
    c) They must be prepared at least monthly and must coincide with one or more pay periods, and
    d) They must be signed by the employee.

e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

i. The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;

ii. At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and

iii. The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

04-39 The Department of Social and Health Services, Division of Vocational Rehabilitation, did not comply with federal time and effort reporting requirements for its Rehabilitation Services grant.

Background

The Department of Social and Health Services, Division of Vocational Rehabilitation, administers the federal Rehabilitation Services-Basic Program (CFDA 84.126). This program provides vocational rehabilitation services for individuals with disabilities so that they may prepare for and engage in gainful employment. For fiscal year 2004, the Department reported total federal program expenditures of $40,334,088, of which $16,754,811 was for wages and benefits.

For payroll costs charged directly to federal awards, federal regulations require employees to document the time and effort spent on each federal activity monthly. These monthly records must reflect the actual distribution of the employee's activities. However, if an employee works on only one federal activity, semi-annual certifications signed by the employee or a supervisor meet federal requirements.

Description of Condition

We found the following:

- The Department charged $114,040 in salaries and benefits to the grant for agency employees whose time was allocated to the program on a strict percentage basis rather than on actual time spent on Program activities.

- Over 300 employees worked and were charged full-time to the Program. The Department did not require these employees or their supervisors to certify their time spent working on the Program. This issue was previously reported in the State of Washington Single Audit report for fiscal year 2003.

Cause of Condition

The Department staff members responsible for the allocation of senior agency staff costs were not familiar with the federal time and effort reporting requirements.

In addition, the Division had developed but not yet put in place policies and procedures to ensure compliance with the federal requirements over time and effort reporting for employees who work 100 percent on a grant program.

Effect of Condition

Without time and effort documentation and certifications, the federal grantor cannot be assured that wages charged to its program are accurate and valid. As a result, we are questioning the $114,040 charged to the Program by employees who spent only part of their time in those activities. However, in considering the nature of the job duties and responsibilities of each field office, we feel the risk is low that the 300 full-time employees were performing duties other than those pertaining to the Program and therefore we do not question these costs.

Recommendation

We recommend the Division:

- For employees spending only part of their time on the Program, charge wages and benefits to the Program based on actual time and effort documentation and discontinue charging these costs on pre-set information in the payroll system.

- Require employees who work 100 percent on a single federal program, or their supervisors, to certify in writing on a semi-annual basis their time spent working on the program.

Department's Response

The Department concurs with this finding. In response to the fiscal year 2003 finding, a corrective action plan was immediately developed and implemented during the next semi-annual certification period of October 1, 2004 through March 31, 2005. The DSHS Accounting Policy Management Board issued Fiscal Policy 50.01, Federal Compliance With Time Allocation/Certification, on July 1, 2004. The Division of Vocational Rehabilitation has implemented the requirements of that policy and semi-annual certifications have been completed for salaried and part-time employees for both the current period and the audit review period. The Department will work towards compliance with federal time and effort reporting requirements.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review these areas in our fiscal year 2005 audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment B, Section 11(h), states in part:

(1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

(2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

(3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

a) More than one Federal award,
b) A Federal award and a non-Federal award,
c) An indirect cost activity and a direct cost activity,
d) Two or more indirect activities which are allocated using different allocation bases, or
e) An unallowable activity and a direct or indirect cost activity.

(5) Personnel activity reports or equivalent documentation must meet the following standards:

a) They must reflect an after-the-fact distribution of the actual activity of each employee,
b) They must account for the total activity for which each employee is compensated,
c) They must be prepared at least monthly and must coincide with one or more pay periods, and
d) They must be signed by the employee.
e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

i. The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
ii. At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
iii. The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

04-40 The Department of Social and Health Services, Juvenile Rehabilitation Administration did not comply with federal requirements for time and effort reporting for the Juvenile Accountability Incentive Block Grant Program.

Background

The Department of Social and Health Services, Juvenile Rehabilitation Administration administers the Juvenile Accountability Incentive Block Grant Program (CFDA 16.523). In fiscal year 2004, the Department spent grant funds of $4,224,808. It awarded 75 percent of this amount as pass-through grants to 48 local governments to conduct juvenile justice activities such as hiring additional judges, prosecutors, public defenders, and probation officers; building or renovating detention facilities; or establishing drug courts.

The Department spent an additional $627,797 for Administration salaries and benefits.

For payroll costs charged directly to federal awards, federal regulations require employees to document the time and effort spent on each federal activity monthly. These monthly reports must reflect the actual distribution of the employee's activities. However, if an employee works only on one federal activity, semiannual certifications signed by the employee or a supervisor meet federal requirements.

Description of Condition

During our review of payroll charges, we noted the Administration did not require any of the employees charged to this grant to account for their time according to federal requirements. All seven salaried employees and the two part-time employees working solely on the Program did not prepare semiannual certifications of their time. In addition, we found two employees working 50 percent of the time on the Program were charging their time based on budgeted rather than actual amounts.

Cause of Condition

The Administration was unaware of the federal requirement regarding time and effort reporting.

Effect of Condition

Without proper time and effort records, the Department cannot substantiate the accuracy of payroll costs charged to this program. We question the entire $627,797 charged to this grant for salaries and benefits.

Recommendation

We recommend the Department maintain time and effort records that comply with federal regulations.

Department's Response

The Department concurs with this finding. The DSHS Accounting Policy Management Board issued Fiscal Policy 50.01, Federal Compliance with Time Allocation/Certification, on July 1, 2004. The Juvenile Rehabilitation Administration (JRA) has implemented the requirements of that policy and semiannual certifications have been completed for salaried and part-time employees for both the current period and the audit review period. JRA employees who work on multiple activities now keep daily timesheets on their activities.

JRA does not concur with the questioned payroll costs of $627,797. It is the administration's position that these funds were expended appropriately within the purpose areas of the federal grant.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review these areas in our fiscal year 2005 audit.

Applicable Laws and Regulations

The U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment B, Section 11(h), states in part:

1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system...or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

    a. More than one Federal award,
    b. A Federal award and a non-Federal award,
    c. An indirect cost activity and a direct cost activity,
    d. Two or more indirect activities which are allocated using different allocation bases, or
    e. An unallowable activity and a direct or indirect cost activity.

5) Personnel activity reports or equivalent documentation must meet the following standards:

    a. They must reflect an after-the-fact distribution of the actual activity or each employee,
    b. They must account for the total activity for which each employee is compensated,
    c. They must be prepared at least monthly and must coincide with one or more pay periods, and
    d. They must be signed by the employee.
    e. Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

        i. The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
        ii. At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
        iii. The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

04-41 The Military Department did not comply with federal requirements for time and effort reporting in the State Domestic Preparedness Equipment Support Program.

Background

The Military Department administers the State Domestic Preparedness Equipment Support Program (CFDA 16.007 and CFDA 97.004), which receives funds from the federal Department of Homeland Security. The funds are provided to enhance the capacity of state and local first responders to respond to a terrorism incident, such as the use of chemical and biological agents or radiological, nuclear, and explosive devices. The Program receives federal funding for the purchase of specialized equipment to improve the capabilities of state and local governments to respond to such acts. The total Program expenditures for fiscal year 2004 are $13,114,108. Included in this amount are the estimated total salaries and benefits of $200,000.

For payroll costs charged directly to federal awards, federal regulations require employees to document their time and effort spent on each federal activity monthly. These monthly records must reflect the actual after-the-fact distribution of an employee's activities. States may charge by budget only if they compare the budget to actual activities at least every three months and adjust requests for federal funds accordingly.

Description of Condition

We found a monthly average of 16 employees working on multiple activities who were keeping monthly time and effort records based on budgeted amounts, rather than on actual amounts.

Cause of Condition

The Department was unaware of the federal requirements regarding time and effort reporting.

Effect of Condition

Without proper time and effort records, the Department is unable to substantiate the accuracy of the payroll costs it charged to this program. We are questioning the estimated $150,000 charged to the program for the salaries and benefits of the 16 employees.

Recommendation

We recommend the Department maintain time and effort records that comply with federal regulations and consult with the federal grantor to determine whether any questioned costs should be repaid.

Department's Response

The Military Department concurs with the finding and has already initiated the following corrective action to address the issue.

In March 2004, during the audit period of July 1, 2003 to June 30, 2004, the Washington Military Department put in place a time and effort policy and procedure. The policy and procedure states clearly that actual time will be reported. To strengthen the implementation of the policy and procedure an additional process has been instituted that has the Payroll section forwarding any timesheet suspected of using budgeted time to the Accounting Manager. In turn the Accounting manager will bring timesheets to the attention of the Emergency Management Division (EMD) Chief of Staff. The EMD Chief of Staff is also directly monitoring timesheets. The monitoring of timesheets by the EMD Chief of Staff has already resulted in timesheets being returned to supervisors and staff to report actual time.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issue identified in the finding. We also appreciate the cooperation extended to us throughout the audit by the Department staff.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87 (2004 version), *Cost Principles for State, Local and Indian Tribal Governments*, Attachment B, Section 8(h), states in part:

(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

(a) More than one Federal award,
(b) A Federal award and a non Federal award,
(c) An indirect cost activity and a direct cost activity,
(d) Two or more indirect activities which are allocated using different allocation bases, or
(e) An unallowable activity and a direct or indirect cost activity.

(5) Personnel activity reports or equivalent documentation must meet the following standards:

(a) They must reflect an after the fact distribution of the actual activity of each employee,
(b) They must account for the total activity for which each employee is compensated,
(c) They must be prepared at least monthly and must coincide with one or more pay periods, and
(d) They must be signed by the employee.
(e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:
    (i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
    (ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
    (iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

04-42 The Department of Social and Health Services, Economic Services Administration, does not adequately monitor other state agencies to which it provides funds from the federal Temporary Assistance to Needy Families Program.

Background

The Department of Social and Health Services, Economic Services Administration, is the administering state agency for the federal Temporary Assistance to Needy Families Program (CFDA 93.558). The Administration receives Program funds from the federal Department of Health and Human Services and, through interagency agreements, shares some of these funds with three other state agencies: the Employment Security Department, the Department of Community, Trade and Economic Development, and the State Board for Community and Technical Colleges. During fiscal year 2004, the Administration received $295,705,817 in Program funds and distributed $141,137,600 of these funds to the three agencies.

Description of Condition

We found the Administration does not receive supporting documents or perform adequate monitoring of the state agencies with which it shares Program funds. The agreement with Employment Security was the only one to mention monitoring activities, and it delegated these activities to the Office of Financial Management. We found no one in the Administration who was monitoring any of the agreements for allowable uses of the funds. As the administering agency, the Department is responsible for ensuring Program funds are used according to federal regulations.

Cause of Condition

The Administration stated it discussed the need for review of supporting documents with the Office of Financial Management and assumed that the Office would monitor these agreements. The Administration's understanding was that the Office would receive and review reports from the three agencies and there was no need for the Department to duplicate this effort. However, we found no one in the Office who was monitoring any of the agreements for allowable uses of the funds.

Effect of Condition

The Administration does not have assurance that Program funds were used for allowable purposes.

Recommendation

We recommend the Administration monitor state agencies receiving Program funds to assure that these agencies are using funds for allowable costs.

Department's Response

The Department partially concurs with this finding. The State Auditor's Office (SAO) audited this program and relevant contracts as recently as two years ago. The SAO had not previously found any questioned costs or issued any audit findings. In the time since SAO audited these contracts, there have been no changes in our procedures concerning these contracts.

Yearly risk assessments that were done on partner agency contracts identified these contracts as 'low risk'. This means the Division of Management and Operations Support (DMOS) reviews each billing for expenditure patterns and appropriateness of those patterns. The Department believes internal controls are in place that help insure consistent and appropriate use of Temporary Assistance to Needy Families Program (TANF) funds by DSHS partner agencies in the WorkFirst Program (WF). Reasonable, timely and thorough back-up practices assure appropriate payments are made on WorkFirst billings (as listed below). Practices within and between the four state WorkFirst partner agencies; Employment Security Department (ESD); Department of Community Trade and Economic Development (CTED); and State Board for Community and Technical Colleges (SBCTC) ensuring the provision of appropriate and accountable use of funds include:

- *A-19 assurances (vendor certification that everything in the billing is true) are signed and accompany all billings. DMOS verifies back up documents with invoice voucher A-19 and monitors for consistent expenditure patterns;*
- *Consistent and thorough documentation (by individual case numbers) exists in the shared automation system, eJAS, to which all administrating partner agencies and all contractors providing services have access and contractual obligation;*
- *Sub-cabinet meetings two and three, quarterly monitor eJAS data including WF partnership statewide performance measures from the program level rising to the Governor's performance measures;*
- *Sub-cabinet meeting three, management through weekly (now bi-weekly) oversight of the WF Partnership's programmatic and fiscal operations as implemented in the field;*
- *Partnership/program collaboration at the local office level helps insure appropriate use of funds – local Community Services Offices, local Employment Security Department Offices, local community and technical colleges, and Community Jobs contractors work together at providing services for shared clients. All WorkFirst client activity is documented in eJAS.*
- *Accountability is mentioned in all Interlocal Agreements:*
    - *CTED -- under "Inspection; Maintenance of Records" – during the agreement and for six years afterwards, the contractor's records shall "demonstrate accounting procedures, practices, and records which sufficiently and properly document the Contractor's invoices to DSHS and all expenditures"*
    - *SBCTC – under "TANF/TANF Maintenance of Effort Compliances" – SBCTC shall provide DSHS with "client and fiscal data necessary to comply with the data reporting provisions"; and, -- under "Inspection; Maintenance of Records" – during the agreement and for six years afterwards, the contractor's records shall "demonstrate accounting procedures, practices, and records which sufficiently and properly document the Contractor's invoices to DSHS and all expenditures."*

In an effort to strengthen current practices, the Department will initiate an action plan to improve documentation and monitoring of WorkFirst partners' billings.

Auditor's Concluding Remarks

We acknowledge monitoring techniques are in place for assessing the overall use of funds at the agencies in question. However, we reaffirm our finding that monitoring is inadequate to provide assurance Program funds are used for allowable purposes.

We appreciate the Department's commitment to resolving the issues identified in the finding by implementing an action plan to improve documentation and monitoring of the WorkFirst partners' billings. We will review the agency's corrective action during our next regular audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

Title 45 of the Code of Federal Regulations, Section 92.40: Monitoring and reporting program performance, states in part:

> (a) Monitoring by grantees. Grantees are responsible for managing the day-to-day operations of grant and subgrant supported activities. Grantees must monitor grant and subgrant supported activities to assure compliance with applicable Federal requirements and that performance goals are being achieved. Grantee monitoring must cover each program, function or activity.

04-43 The Department of Social and Health Services, Juvenile Rehabilitation Administration is not complying with subrecipient monitoring requirements for the Juvenile Accountability Incentive Block Grant.

Background

State agencies often distribute federal funds to other organizations that provide services needed to accomplish federal program objectives. These organizations are known as subrecipients, while the state agencies are called pass-through agencies.

To help ensure that funds are spent appropriately, the federal government requires pass-through agencies to monitor the activities of subrecipients to provide reasonable assurances they are complying with federal requirements. Monitoring includes reviewing reports submitted by subrecipients and performing on-site reviews of subrecipients financial, operations and program records.

In fiscal year 2004, the Department spent grant funds of $4,224,808 from the Juvenile Accountability Incentive Block Grant (CFDA 16.523). It awarded 75 percent of this amount as pass-through grants to 48 local governments to conduct juvenile justice activities such as hiring additional judges, prosecutors, public defenders, and probation officers; building or renovating detention facilities; or establishing drug courts.

Description of Condition

We reviewed the Department's system for monitoring the activities of these subrecipients and its process for paying subrecipient claims. The monthly claims from the local governments include salaries and benefits, contractual services, travel and administrative costs. We found the local governments do not submit supporting cost documentation with reimbursement claims. A review of financial documentation during on-site visits would provide a compensating control, but we found the Department does not perform such a review.

Local governments submit progress reports quarterly, and the Department withholds payment if the report is not received. While this is an important method of monitoring, it does not provide a review of financial information.

Cause of Condition

The Department said it is aware of the need to review subrecipient financial information but lacked the staff to meet this responsibility.

Effect of Condition

The Department cannot ensure its subrecipients are complying with federal requirements and are using funds for allowable purposes. This could jeopardize future federal funding for the program.

Recommendation

We recommend the Department review financial documentation supporting subrecipient reimbursement claims, either before payment or during on-site visits.

Department's Response

The Department concurs with this finding. The JAIBG Program Site Review form, which is completed during each on-site visit annually, has been revised to include a review of financial information. This review will include all support cost documentation for reimbursement claims for a specific time period. Site visits are scheduled with each site by the program administrator, or in the case of some remote sites, the Juvenile Rehabilitation Administration regional administrator for the region in which the site resides. Site visits that take precedence are those that are considered higher risk or contract terms that are soon to expire.

In addition, DSHS Administrative Policy 13.14, Identifying and Managing Federal Sub- recipient Contracts and Agreements is currently being reviewed at the executive level; we anticipate the policy will be finalized and released by March 31, 2005.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review these areas in our fiscal year 2005 audit.

Applicable Laws and Regulations

The U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section .400(d), states in part:

> Pass-through entity responsibilities. A pass-through entity shall perform the following for the Federal awards it makes: . . .
>
> (3) Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

Office of Juvenile Justice and Delinquency Prevention, Grant Award Number 2002-JB-BX-0040, states in part:

> Special Conditions
>
> 11. The recipient agrees to monitor all subawards for performance and fiscal integrity, including cash match. In addition, the recipient will monitor all subrecipients to assure that required audits are performed.

04-44 The Department of Social and Health Services, Health and Rehabilitative Services Administration, does not adequately monitor its subrecipients for the Community Mental Health Services Block Grant.

Background

State agencies often distribute federal funds to organizations that provide services needed to accomplish federal program objectives. These organizations are known as subrecipients, while the state agencies are called pass-through agencies.

To help ensure that funds are spent appropriately, the federal government requires pass-through agencies to monitor the activities of subrecipients to provide reasonable assurances they are complying with federal requirements. Monitoring includes reviewing reports submitted by subrecipients, reviewing audit reports for the subrecipients, and performing on-site reviews of subrecipient financial, operational and program records.

The Department of Social and Health Services, Mental Health Division, administers the federal Community Mental Health Services Block Grant (CFDA 93.958). This Program provides funds to states and territories to help them provide comprehensive, community-based mental health services for adults with serious mental illness and children with serious emotional disturbances.

The Department contracts with Regional Support Networks and other contractors who administer the Program throughout the state. These subrecipients must submit plans to the Administration documenting how they will use the funds. Each month the subrecipients submit claims for reimbursement to the Department for services provided while following their plans. In fiscal year 2004, the Department spent $8,697,249 in this Program.

Description and Effect of Condition

We reviewed the Division's process for monitoring the activities of the subrecipients and for paying their claims. We found the Division does not require them to submit supporting documentation of their costs with their reimbursement claims, although some do. The Division does not perform on-site reviews of subrecipients who don't provide supporting documentation; such reviews would provide a compensating control. Without proper documentation or on-site reviews, the Division cannot be certain its subrecipients have spent grant funds for allowable purposes.

We also found the Division has no adequate process in place to ensure it receives all required reports of independent audits of subrecipient federal funds, reviews those reports, and follows-up on any needed corrective action. Without such a process, the Division cannot ensure it or its subrecipients have complied with federal requirements for subrecipient audits.

Cause of Condition

The Division believed it did not need to monitor because its subrecipients receive audits of their federal funds performed by the State Auditor's Office. However, the federal government has made it clear that such reliance is not sufficient to meet the recipient's (in this case, the Division) responsibilities towards its subrecipients and towards the federal grantor.

Recommendation

We recommend the Division establish and follow a process to:

- Require the submission of adequate payment support by all subrecipients or perform an on-site review of this support.
- Monitor subrecipients requiring an audit in accordance with federal regulations by:
    - Establishing a record of all such audits it needs to receive and ensuring it receives them.

- Performing a timely review of these audit reports, followed by timely management decisions on audit findings.

- Requiring timely corrective action on audit issues.

Department's Response

The Department concurs with this finding.

The Mental Health Division (MHD) will develop a contract monitoring process for all contracts, including, but not limited to, the Mental Health Block Grant contracts. In addition MHD will implement DSHS Administrative Policy 13.14, Identifying and Managing Federal Subrecipient Contracts and Agreements scheduled for release March 31, 2005.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding and will review these areas in our fiscal year 2005 audit.

Applicable Laws and Regulations

The U.S. Office of Management and Budget's Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section .400(d), states in part:

> **Pass-through entity responsibilities.** A pass-through entity shall perform the following for Federal awards it makes:
>
> (3) Monitor the actives of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.
>
> (4) Ensure that subrecipients expending $300,000 or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
>
> (5) Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
>
> (6) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records . . . .

04-45 The Military Department does not have adequate internal controls to ensure compliance with regulations regarding purchases for, contracting with, and monitoring of its subrecipients in the State Domestic Preparedness Equipment Support Program.

Background

State agencies often distribute federal funds to other organizations that provide services needed to accomplish federal program objectives. These organizations are known as subrecipients, while the state agencies are called pass-through agencies. To help ensure that funds are spent appropriately, the federal government requires pass-through agencies to monitor the activities of subrecipients to provide reasonable assurance that they are complying with federal requirements. Monitoring requirements are contained in the federal Office of Management and Budget's Circular A-133, *Audits of States, Local Governments, and Non-profit Organizations*.

Monitoring may take various forms, such as reviewing reports submitted by subrecipients; regular contact with subrecipients; and performing on-site reviews of subrecipient financial and program records and operations. Factors that may affect the degree of monitoring include program complexity, amount of the award, and risks directly related to the subrecipient. Pass-through agencies must ensure they receive and review audit reports from subrecipients and follow-up on any problems identified in those reports.

The Military Department administers the State Domestic Preparedness Equipment Support Program (CFDA 16.007 and CFDA 97.004), which receives funds from the federal Department of Homeland Security. The funds are provided to enhance the capacity of state and local first responders to respond to terrorism, such as the use of chemical and biological agents or radiological, nuclear, and explosive devices. The Program receives federal funding for the purchase of specialized equipment to improve the capabilities of state and local governments to respond to such acts. Total Program expenditures for fiscal year 2004 were $13,114,108.

In addition to its own activities, the Department contracts with all 39 counties of the state to provide funds for the purchase of specialized equipment and for training exercises, planning and administration. These counties are subrecipients of the Department and together received $12,845,271of the Department's federal equipment grant during fiscal year 2004.

Description of Condition

During our review, we found the Department has:

- Inadequate controls over the approval of equipment purchases made by the Department and sent to the subrecipient counties. There is no evidence that the program manager is reviewing and approving the equipment purchases.

- Inadequate information in subrecipient contracts regarding subrecipient obligations to record and track equipment purchased with federal funds.

- Inadequate procedures for monitoring the activities of its subrecipients. There is no system in place to perform periodic on-site visits of subrecipients, nor to collect, review, and follow-up on subrecipient audit reports.

Cause of Condition

The Department was unaware of the need to have adequate procedures to ensure equipment is purchased properly, subrecipient contracts include equipment controls, and subrecipient audit reports are received and reviewed. The Department stated it was aware of the need to review subrecipient financial information during on-site visits but lacked the staff to conduct such visits.

Effect of Condition

Inadequate internal controls increase the risk of loss of public funds. In addition, these conditions impair the Department's ability to prevent or detect errors and irregularities in a timely manner.

Recommendation

We recommend the Department:

- Establish and follow adequate internal controls to ensure it makes only allowable equipment purchases with grant funds.
- Devote the resources necessary to ensure it properly monitors its subrecipients. At a minimum, the Department should:
    - Communicate the federal equipment management requirements to all subrecipients.
    - Periodically check that all subrecipients have an adequate system for equipment recording, usage, inventorying and disposition.
    - Check annually to see if counties received an audit of the program, when required.

Department's Response

The Military Department concurs with the finding and has already initiated the following corrective action to address the issues.

An oversight management group has been established and has met to direct the development and implementation of sub-recipient monitoring policy and procedures. A comprehensive written agency policy and procedure will be completed by 03/31/05. Training will be provided to program staff that will be involved in monitoring sub-recipients. The progress of writing and implementing the policy and procedures will be reported to the Director of the Washington Military Department on a monthly basis until fully implemented.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolving the issues identified in the finding. We also appreciate the cooperation extended to us throughout the audit by the Department staff.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section .400(d), states in part:

> A pass-through entity shall perform the following:
>
> Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved . . .
>
> Ensure that subrecipients expending $300,000 or more in Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.
>
> Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
>
> Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.

The Department of Homeland Security has established the Office of Justice Programs' *Financial Guide* as the fiscal and oversight requirements for this grant program. Part II, Chapter 3 of this guide states in part:

> 1. Reviewing Financial Operations. Direct recipients should be familiar with, and periodically monitor, their subrecipients' financial operations, records, system, and procedures. Particular attention should be directed to the maintenance of current financial data . . .
>
> 5. Audit Requirements. Recipients must ensure that subrecipients have met the necessary audit requirements contained in this Guide (see Part III, Chapter 19: Audit Requirements).
>
> Where the conduct of a program or one of its components is delegated to a subrecipient, the direct recipient is responsible for all aspects of the program including proper accounting and financial recordkeeping by the subrecipient. Responsibilities include the accounting of receipts and expenditures, cash management, the maintaining of adequate financial records, and the refunding of expenditures disallowed by audits.

Part III, Chapter 19 of the Guide states in part:

> When subawards are made to another organization or organizations, the recipient shall require that subrecipients comply with the audit requirements set forth in this chapter.
>
> Recipients are responsible for ensuring that subrecipient audit reports are received and for resolving any audit findings. Known or suspected violations of any law encountered during audits, including fraud, theft, embezzlement, forgery, or other serious irregularities, must be communicated to the recipient.
>
> For subrecipients who are not required to have an audit as stipulated in OMB Circular A-133, the recipient is still responsible for monitoring the subrecipients' activities to provide reasonable assurance that the subrecipient administered Federal awards in compliance with Federal requirements

Part III, Chapter 6 of the Guide states in part:

> Records for equipment, non-expendable personal property, and real property shall be retained for a period of three years from the date of the disposition or replacement or transfer at the discretion of the awarding agency. If any litigation, claim, or audit is started before the expiration of the three-year period, the records shall be retained until all litigations, claims, or audit findings involving the records have been resolved.

04-46 The University of Washington did not comply with federal grant requirements for two of its research and development programs.

Description of Condition

The University has approximately 500 organizational units that receive federal assistance for research and development programs. Organizational units are used to account for financial information based for the University. From July 1, 2003 through June 30, 2004, the University spent approximately $600 million in federal funds for its research and development programs. These federal programs are audited in accordance with federal standards that require questioned costs in excess of $10,000 to be reported. Based on our review of expenditures, we selected nine university departments to audit. These departments spent $129,596,467 or approximately 25 percent of total federal research and development assistance. In the course of our audit, we identified questioned costs in two of the departments, totaling $36,509.

Center for AIDS and STD

The Center for AIDS and STD provides patient care, research, training and education, and international assistance for HIV/AIDS and sexually transmitted disease. The Microbiology and Infectious Diseases Research grant (CFDA 93.856) in the amount of $44,675,057, supports research related to Microbiology and Infectious Diseases with the aim of improving health by controlling disease caused by infectious or parasitic agents. The Center for AIDS and STD's program awarded under this grant is the Adult AIDS Clinical Trials Unit, which conducts clinical research in order to answer questions about how HIV works and affects the immune system. During the period July 1, 2003, through December 31, 2003, this program spent $819,678 from the National Institute of Health.

We noted the following costs that were improperly charged to this federal program:

- $17,888 in salary and benefits paid to the Assistant Director that were not based on actual effort as required by federal regulations.

- $2,104 in miscellaneous supplies and shipping charges that were not used to support the program.

Department of Radiology

The Department of Radiology operates within the University's School of Medicine. The Arthritis, Musculoskeletal and Skin Diseases Research grant (CFDA 93.846) in the amount of $11,813,933, supports research, research training, and basic and clinical investigations. The Department of Radiology's program awarded under this grant is the MR & Optical Diagnosis of Muscle Metabolism and Function, which uses a combination of magnetic resonance and optical spectroscopes to study human muscle energy metabolism. During the period July 1, 2003, through June 30, 2004, this program spent $637,926 from the National Institute of Health.

We noted the following costs that were improperly charged to this federal program:

- $16,517 in salaries and benefits paid to the principal investigator and co-principal investigator that were not based on actual effort as required by federal regulations.

Cause of Condition

The Center for AIDS and STD and the Department of Radiology did not develop adequate procedures to ensure that costs were charged properly.

Effect of Condition

The Center for AIDS and STD and the Department of Radiology inappropriately received reimbursement for costs that were unallowable.

These conditions resulted in $19,992 in questioned costs charged to the Microbiology and Infectious Diseases Research grant and $16,517 in questioned costs charged to the Arthritis, Musculoskeletal and Skin Diseases Research grant.

Recommendations

We recommend:

- The Center for AIDS and STD and the Department of Radiology take steps to ensure that only allowable costs are charged to its programs.

- The University remove the unallowable costs charged to its programs.

University's Response

Taking steps:
We agree. The Department of Radiology has implemented new control mechanisms for tracking and follow-up to ensure that payroll certifications and budget reports are timely reviewed and approved. Errors noted by the auditors at the Center for AIDS and STD occurred during a period of rapid program growth while there were several significant personnel matters with support staff. To address these problems, the Center has hired additional staff (1.5 FTE), responsibilities have changed to provide more oversight, and employees are being cross-trained to provide backup support. Also, new procedures have been introduced to strengthen controls.

Removing costs:
We agree. The University has removed the above questioned costs from the federal programs improperly charged and applied them to the proper programs.

Auditor's Remarks

We appreciate the University's response. We will review the University's corrective actions during the next regularly scheduled audit.

Applicable Laws and Regulations

Office of Management and Budget Circular A-21, Section C, which requires costs to be reasonable and allocable to the sponsored agreement, defines allocable costs in subsection 4.a as:

> A cost is allocable to a particular cost objective (i.e., a specific function, project, sponsored agreement, department, or the like) if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received or other equitable relationship. Subject to the foregoing, a cost is allocable to a sponsored agreement if (1) it is incurred solely to advance the work under the sponsored agreement; (2) it benefits both the sponsored agreement and other work of the institution, in proportions that can be approximated through use of reasonable methods, or (3) it is necessary to the overall operation of the institution and, in light of the principles provided in this Circular, is deemed to be assignable in part to sponsored projects.

Office of Management and Budget Circular A-21, Section C, subsection 4.d further states:

> (1) *Cost principles*. The recipient institution is responsible for ensuring that costs charged to a sponsored agreement are allowable, allocable, and reasonable under these cost principles.
> (2) *Internal controls*. The institution's financial management system shall ensure that no one person has complete control over all aspects of a financial transaction.

(3) *Direct cost allocation principles*. If a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost should be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then, notwithstanding subsection b, the costs may be allocated or transferred to benefited projects on any reasonable basis, consistent with subsections d.(1) and (2).

04-47 The Employment Security Department does not have adequate internal controls over the reporting of grant expenditures on the Schedule of Expenditures of Federal Awards.

Background

The Employment Security Department administers the benefit provisions of the federal Trade Adjustment Assistance Workers Program (TAA) and the North American Free Trade Agreement Assistance Act (NAFTA). Funds for these two programs are separately granted, and the federal Department of Labor requires their expenditures to be separately tracked and reported; however, both programs are included in CFDA 17.245.

Both programs provide testing, counseling, and job placement services; job search and relocation assistance; training; and payment of weekly subsistence allowances to workers whose unemployment is the result of increased imports or shifts in production to certain countries. During fiscal year 2004, these programs together spent $30,964,797 for administrative activities and for benefits to 8,485 participants.

For the State of Washington Schedule of Expenditures of Federal Awards included in the State of Washington Single Audit Report, each agency is required to report total fiscal year expenditures for each federal program by federal agency and the identifying Catalog of Federal Domestic Assistance (CFDA) number. These amounts are reported to the Office of Financial Management (OFM) to be consolidated into the final Schedule.

Description of the Condition

The Department has not established sufficient internal controls to ensure its expenditures reported for CFDA 17.245 are accurate and complete. We found the following weaknesses:

- There was inadequate support for the total amount originally reported on the Schedule and submitted to OFM.
- No one had reconciled the TAA grant activity included in the total to other Department records to ensure it included all the benefits paid to participants.

Cause of Condition

The Employment Security Department provided the following cause:

The Employment Security Department recorded revenue received for Federal Unemployment benefits issued to eligible claimants under CFDA.17.225. In FY04 it was learned that Federal reimbursements received through the UI Grant for TRA benefit expenditures are to be recorded as revenue under CFDA 17.245. The department prepared the AFRS entries to move the FY04 revenue to the correct CFDA, 17.245. When analyzing the accounting records to prepare the correction, the accrued revenue for FY04 TRA benefits was inadvertently left in CFDA 17.225. This amount totaled approximately $528,000.00.

Effect of Condition

The Department did not originally report its expenditures for these programs accurately. It initially indicated that the Schedule correctly reflected the grant expenditures. We were able to verify through independent sources that the portion of the expenditures related to grant administration was supported by the Department's financial documentation. However, financial documents provided to us for the benefit portion of expenditures did not agree with the amounts used to calculate the total for the Schedule. Based on our review of the documents the Department was able to provide, the Schedule was understated by approximately $528,000. The Office is currently working with the Department to correct its reported amounts on the Schedule.

Recommendations

We recommend that the Department:

- Ensure it has adequate supporting documents for its financial reporting to the federal government.

- Establish and follow adequate reconciliation procedures to verify its grant expenditures reported in the Schedule are accurate.

Department's Response

Effective July 1, 2004 all Trade Act benefit transactions have been recorded properly in the department's accounting system under CFDA 17.245. Also, additional AFRS (Agency Financial Reporting System) codes were created to allow for more detailed tracking of Federal Unemployment Insurance benefits. These codes show the details of all Federal benefit activity separately, instead of combined as one total. This change will remove any confusion over the CFDA codes to use for reporting and will give the department the ability to accurately report Federal benefits issued at the needed detail level. It will also allow the department to accurately report Trade Act activities on the Schedule of Expenditure of Federal Awards (SEFA). In addition, a monthly reconciliation of Trade Act benefit expenditures will be performed to ensure all entries are correct.

The department's fiscal year 2004 SEFA will be corrected to reflect the actual revenue and expenditure amounts for the Trade Act program.

Auditor's Concluding Remarks

We appreciate the cooperation provided by the Department staff during this audit. We note the Department submitted a request to correct this program's expenditure data and the Office of Financial Management made the correction to the Schedule. We will review the Department's corrective actions during the next review of this program.

Applicable Law and Regulations

Office of Management and Budget's Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section .310(b)(3), of the federal 87, *Cost Principles for State, Local and Indian Tribal Governments*, states the auditee must:

Provide total Federal awards expended for each individual Federal program and the CFDA number or other identifying number when the CFDA information is not available.

The Office of Financial Management's *State Administrative and Accounting Manual*, Sections 95.10.40.a states:

Each state agency or institution that expends awards of federal assistance during a state fiscal year must complete federal electronic disclosure forms provided by OFM's Accounting Division. To meet federal reporting requirements, agencies must report all federal assistance received, disbursed, and/or on hand and must complete the "Federal Assistance Certification." Both the agency head and chief financial officer are to certify, to the best of their knowledge, that the agency complied with federal assistance requirements and that the information reported by the agency is complete and accurate. The cutoff deadline date for completing federal disclosure forms is published annually by OFM.

Section 95.10.40.d of the *Manual* states:

Direct federal assistance is to be reported at the individual federal program and identified by Catalog of Federal Domestic Assistance (CFDA) number, federal program title, and federal program cluster designation....

04-48 The Employment Security Department did not comply with federal requirements for time and effort reporting.

Background

The Employment Security Department administers the benefit provisions of the federal Trade Adjustment Assistance Workers Program (TAA) and the North American Free Trade Agreement Assistance Act (NAFTA). Funds for these two programs are separately granted, and the federal Department of Labor requires their expenditures to be separately tracked and reported; however, both programs are included in CFDA 17.245.

Both programs provide testing, counseling, and job placement services; job search and relocation assistance; training; and payment of weekly subsistence allowances to workers whose unemployment is the result of increased imports or shifts in production to certain countries. During fiscal year 2004, these programs together expended $30,964,797 for administrative activities and for benefits to 8,485 participants.

When participants have exhausted these benefits, additional benefits may be available to them from the Workforce Investment Act (WIA) program cluster, which are other grants provided by the U.S. Department of Labor (CFDA 17.258-17.260).

For payroll costs charged directly to federal awards, federal regulations require employees to document their time and effort spent on each federal activity monthly. These monthly records must reflect the actual after-the-fact distribution of the employee's activities. However, if an employee works on only one federal activity, semi-annual certifications signed by the employee or supervisor meet federal requirements. States may charge by budget only if they compare the budget to actual activities at least every three months and adjust requests for federal funds accordingly. Employees at the Department fill out semi-monthly timesheets and sign certifications indicating that the time documented consists of actual working hours or leave taken during the period.

Description of Condition

During our review of TAA and NAFTA, we selected 25 of the 67 employees who charged time for these programs during fiscal year 2004 and reviewed the support for payroll charges. We analyzed documentation and held discussions with the employees. We found that 21 of the employees were given instructions to charge their hours on some basis that did not reflect their actual activities. While the methods used were inconsistent, our review indicates the instructions were based on management decisions to use more grant funding than would otherwise occur in order to prevent certain funds from lapsing at stated deadlines. We identified at least $130,515 in costs inappropriately charged between TAA and NAFTA. In addition, we found that eight of the 21 employees charged significant time to WIA but no time to TAA, even though the clients they served were mostly from TAA.

We also noted that indirect charges are not charged properly either, because the agency uses time and effort charges to allocate its indirect costs to various federal funding sources. Based upon the testing of timesheets, we believe that indirect charges were misstated for an unknown amount in TAA, NAFTA and WIA.

Cause of Condition

Management did not always follow the policies set by the Commissioner of the Department.

Effect of Condition

Without proper time and effort records, the Department is unable to substantiate the accuracy of the costs charged to the administration of these grants. We are questioning the $130, 515 that was inappropriately charged to TAA and NAFTA. Because of the improper hours charged to WIA and the incorrect calculation of indirect charges, the total unallowable costs for these three programs are difficult to determine.

Recommendation

We recommend the Department maintain time and effort records that comply with federal regulations and consult with the federal grantor to determine whether any questioned costs should be repaid.

Department's Response

It is recognized and accepted within the WorkSource Operations Division (WSOD) that management and staff in all programs, including the Trade Adjustment Assistance Program, need to adhere to the policies and procedures surrounding the requirements for time and effort reporting. The WSOD will be working with the regional offices to reinforce the agency message to all staff in the local offices on the importance of accurate time and effort reporting.

In the near future the WorkSource Operations Division will be conducting refresher training of all managers and supervisors statewide to ensure understanding of the Commissioner's Memo on "Accurate Time Reporting" dated July 22, 2003.

Following are the responses from each region on how they will be strengthening their processes to ensure that offices follow the policies as set by the Commissioner of the Department to comply with federal requirements for time and effort reporting. It should be noted that costs being questioned by the auditor in this finding resulted from time reported by staff to components (TAA/NAFTA) of the same federal program. Funding for NAFTA has subsequently been discontinued.

Puget Sound Region

This subject was an agenda item at the Regional WorkSource Administrator's meeting on April 6, 2005 and will also be discussed at their meeting on April 20, 2005. The discussion at this meeting will focus on the six expectations listed in the previous Commissioner' s memo dated July 22, 2003, titled "Accurate Time Reporting". Each Administrator will receive a copy of this memo.

- ***King County (includes WorkSource Auburn & WorkSource Renton offices)***
  The King County WorkSource Administrator addressed this issue with their leadership team on April 7, 2005. In addition to providing examples to the supervisors on how to discuss the importance of this topic to staff, the Administrator also discussed the role and expectations of the supervisor in the time reporting process. This Administrator also assigned the Operations Manager to conduct a random review of time sheets every pay period.

- ***Snohomish County (includes WorkSource Everett office)***
  Corrective action has been initiated by Snohomish County WorkSource offices regarding the accurate time reporting issue. The WorkSource Administrator has sent an e-mail containing the requirements for accurate time reporting to all of his supervisors. Also, the WorkSource Administrator provided an example that the supervisors could use while talking with staff about this topic.

  The WorkSource Snohomish County Administrator has communicated the following information to local ESD management & staff:
  - *Time sheets are not budget driven.*
  - *Staff should be made aware of their work assignment and the work assignment should line up with what has been budgeted.*
  - *If work assignments do not match up with budgets, then office management will need to address it.*
  - *Staff should fill out their time sheets on a daily basis and they should reflect the type of work they performed.*
  - *Each supervisor will check time sheets every pay period to make sure there is not a repetitive pattern in the time sheet. Supervisors will talk with staff completing timesheets with a repetitive pattern and explain the above requirements on how they are to complete their time sheet.*

West Region

- ***Clallam County WorkSource (includes Port Townsend office)***
  The following corrective action was taken in the WorkSource Clallam County (covering Port Angeles/Port Townsend offices) area in response to areas of concern related to accurate time reporting (TAA/NAFTA Programs):

- *TAA/NAFTA activities have been assigned to one staff person for the Olympic Workforce Development Area (Bremerton / Port Angeles / Port Townsend). This is his sole responsibility and he will be charging 100% of his time to this program.*
- *The TAA project where most of the time and effort report issues occurred is closed.*
- *The project manager who authorized the time charging retired. The new supervisor overseeing the time charging for the program staff has been trained on accurate time reporting procedures.*

- ***Pierce County (includes Tacoma WorkSource office)***
  The staff person serving Trade Act clients in Tacoma stated she misunderstood as to how to charge her time as she felt the NAFTA and TAA programs were consolidated and so she estimated her time spent serving clients in each. Effective July 1, 2004, this employee has only one code (TAA) to which she will charge her time.

Cascade East Region

- ***WorkSource Spokane***
  In State Fiscal Year 2004 staff were instructed and expected to charge their time accurately based upon the program participants they were serving. Staff were given program descriptions and charge codes to assist them in making decisions about which program to charge on their timesheets. Staff tools include using either a desk calendar and/or an Outlook calendar, and many staff make daily entries to their timesheet that reflect their time usage.

  The office Financial Analyst did provide staff with a chart that reflected budget plans by program. This chart did include the percentage of salaries budgeted to each program. However, it was never intended that staff charge their time based upon a planned budget.

  To prevent any further misunderstandings, the practice of issuing budget plans with charge codes and percentages has stopped. Only charge codes are to be given to staff with instructions to accurately report their time on their timesheets based upon the customers they are serving.

- ***WorkSource Columbia Gorge***
  The supervisor in question charged 59 hours to the NAFTA code over a 6-month period between January and June 2004. During this time period, he also charged a significant number of hours (188) to the "9/11 Rapid Response National Emergency
  Grant (NEG)" code. The 9/11 Rapid Response NEG allocation was designated to serve TAA participants. The supervisor's duties for hours charged to the 9/11 Rapid Response
  NEG and NAFTA involved supervision of the two programs, which are operated together.

  As he mentioned in his response to the auditor, his time charged to NAFTA was spent directly supervising staff, managing performance, attending meetings impacting TAA/NAFTA operations, reviewing client files, approving and signing payment
  vouchers, coordinating activities with other WorkSource programs for seamless integration, coordinating with the regional Dislocated Worker Program Manager on service integration, and researching and implementing of quality improvement processes on a local level. We do not believe time charges made by this employee were inappropriate.

Statewide, the staff identified through this review are now aware that their time is to be charged on a daily basis and is distributed by project codes that reflect actual activities performed. They will fill out their time sheets and use proper charge codes according to the duties performed each day.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolve the issue identified in the finding and will review the Department's progress in our 2005 audit. We also appreciate the cooperation extended to us throughout this audit by Department staff.

Applicable Laws and Regulations

Attachment A, Section C.3.a. of the Office of Management and Budget's Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, requires allocable costs to be chargeable or assignable in accordance with the relative benefits received.

Attachment B, Section 8(h) of the Circular states in part:

4) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

5) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation...unless a statistical sampling system or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

    a) More than one Federal award,
    b) A Federal award and a non-Federal award,
    c) An indirect cost activity and a direct cost activity,
    d) Two or more indirect activities which are allocated using different allocation bases, or
    e) An unallowable activity and a direct or indirect cost activity.

6) Personnel activity reports or equivalent documentation must meet the following standards:

    a) They must reflect an after-the-fact distribution of the actual activity of each employee,
    b) They must account for the total activity for which each employee is compensated,
    c) They must be prepared at least monthly and must coincide with one or more pay periods, and
    d) They must be signed by the employee.
    e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

        i. The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;

        ii. At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and

        iii. The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

On July 22, 2003, the former Commissioner of the Department issued a memo to agency management entitled Accurate Time Reporting. The memo provided the following guidance:

> We must be able to identify the actual cost of these programs and demonstrate to our funding sources that charges through our time distribution system have a direct relationship to the level of services we provide to our customers.
>
> The allocation of costs to our agency programs is driven by the time reporting system. If the accuracy of our time reporting is compromised, the true cost of operating those programs cannot be determined. Questioned or disallowed costs can result.
>
> I am asking managers, supervisors, and staff to follow the time reporting principles listed below:

1. Employees will fill out their own time sheets by computer or in ink. The employee should initial any changes made after the employee has completed and signed the time sheet.

2. Time reported to a program will be based on the employee's best estimate of the time spent on that program.

3. Supervisors are not to request an employee change time reported unless an error has been made (examples: expired project code, transposed numbers).

4. Supervisors will direct the activities of the staff, not manage or influence the time sheets they fill out.

5. Time reported to a program should be consistent with and traceable to records of service provided (if applicable).

6. Managers intending to use any recurring percentage distribution method for salaries other than Projects 9997 and 9998 (AS&T) or Project 9999 (Cost Center Allocation) must receive pre-approval to do so from the agency Budget Office. Approval will be contingent upon the submission of an allocation plan that describes whose time will be distributed based on the plan and how the percentages will be determine (sic).

04-49 The Department of Social and Health Services' Medical Assistance Administration did not comply with allowability and reporting requirements for the State Children's Health Insurance Program.

Background

The Department of Social and Health Services administers the federally-funded State Children's Health Insurance Program (CFDA 93.767), which provides health care to uninsured, low-income children not eligible for Medicaid. The Department has assigned responsibility for the Program to the Medical Assistance Administration. Total Program payments during fiscal year 2004 were approximately $36 million.

Effective August 15, 2003, qualifying states are allowed to use up to 20 percent of their federal fiscal year 1998-2001 Program awards to help pay for coverage for state Medicaid-eligible children whose family income falls within certain limits. These funds may be used only for federal fiscal years 2004 and 2005. Requests for reimbursement from the federal grantor must be based on actual, not estimated, payments.

In addition, the federal government approved an amendment to the Program's State Plan that added coverage for unborn children not eligible for Medicaid. Under this amendment, prenatal care and associated health services are covered from conception to birth. The effective date of the amendment was November 12, 2002.

Description of Condition

We found the Administration reported payments and requested and received federal Program reimbursements for:

- Children's Medicaid expenditures that were based on estimated amounts rather than on actual payments. Total payments involved were approximately $22 million.

- Prenatal medical expenditures that were paid prior to the November 12, 2002 effective date. Total payments involved were approximately $4.3 million.

Cause of Condition

Administration managers stated they had insufficient time to obtain the actual amounts for Program payments made from Departmental systems. They also stated they are currently working to obtain actual amounts for fiscal years 2004 and 2005. We will review this information during our fiscal year 2005 audit.

Administration managers interpreted the State Plan amendment to allow them to claim prenatal payments for children born on the effective date.

Effect of Condition

The Department may have received federal funds to which it is not entitled. We question the approximately $26.3 million received by the Department based on estimated costs and on costs incurred before the effective date.

Recommendations

We recommend the Administration base its requests for federal Program reimbursements on:

- Actual rather than estimated payments for Medicaid-eligible children whose family incomes fall within certain limits.

- Payments made for prenatal services provided only after the effective date of the State Plan amendment.

We also recommend the Administration consult with the federal grantor to determine if any funds received must be returned.

Department's Response

This finding encompasses two issues uncovered by the auditor.

First, amounts claimed for higher income children covered under the program were based on estimated costs rather than actual costs. These estimates were used for federal reporting and Medicaid claiming purposes. The Department agrees with this finding. Procedures have been changed to claim actual costs rather than estimated costs and an adjustment to the quarterly Medicaid claim will be submitted to reflect actual costs for the time period of the audit.

Second, the Department received authorization from the federal Centers for Medicare and Medicaid Services (CMS) to claim the cost of prenatal care for undocumented low income women under the State Children's Health Insurance Program. These costs could be claimed as of November 12, 2002, the date of the authorization. The Department misinterpreted the date as
of (sic) which services could be claimed, and claimed services before the authorization date. The Department agrees with this finding. CMS has been contacted and repayment of the unauthorized services will be made.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolve the issues identified in the finding and will review Department's progress in our 2005 audit. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

Title 42 Code of Federal Regulations, Section 457.630(c), states:

> Expenditure reports. (1) The State must submit Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) and Form CMS-21 (Quarterly State Children's Health Insurance Program Statement of Expenditures for title XXI), to central office (with a copy to the regional office) not later than 30 days after the end of the quarter. (2) This report is the State's accounting of actual recorded expenditures. This disposition of Federal funds may not be reported on the basis of estimates (Emphasis added).

State Children's Health Insurance Program State Plan Amendment number 4 states:

> Addition of SCHIP Coverage for Prenatal Care and Associated Health Care Services to the State Child Health Plan
>
> State/Territory: Washington
>
> Section 4. Eligibility Standards and Methodology. (section 2102/(b))
>
> 4.1.2.1 Age: Conception through birth
>
> 4.1.3.1 Income:
> 0% of the FPL (and not eligible for Medicaid) through 185% of the FPL
> Effective Date: 11/12/02 (date costs begin to be incurred)
>
> Implementation Date: 11/12/02 (date services begin to be provided)